EXAMINING THE FISCAL YEAR 2016 HHS BUDGET

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

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[1] Secretary Burwell did not respond to submitted questions by the time of printing.

[2] Available at: *http://docs.house.gov/meetings/if/if14/20150226/103028/hmtg-114-if14-20150226-sd008.pdf*

EXAMINING THE FISCAL YEAR 2016 HHS BUDGET

THURSDAY, FEBRUARY 26, 2015

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:03 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Guthrie, Barton, Whitfield, Shimkus, Murphy, Burgess, Lance, Griffith, Bilirakis, Ellmers, Bucshon, Collins, Upton (ex officio), Green, Engel, Capps, Schakowsky, Butterfield, Castor, Sarbanes, Matsui, Lujan, Schrader, Kennedy, Cardenas, and Pallone (ex officio).

Staff present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Sean Bonyun, Communications Director; Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary; Andy Duberstein, Deputy Press Secretary; Paul Edattel, Professional Staff Member, Health; Robert Horne, Professional Staff Member, Health; Charles Ingebretson, Chief Counsel, Oversight and Investigations; Peter Kielty, Deputy General Counsel; Carly McWilliams, Professional Staff Member, Health; Emily Newman, Counsel, Oversight; Katie Novaria, Professional Staff Member, Health; Tim Pataki, Professional Staff Member; Michelle Rosenberg, GAO Detailee, Health; Krista Rosenthall, Counsel to Chairman Emeritus; Adrianna Simonelli, Legislative Clerk; Alan Slobodin, Deputy Chief Counsel, Oversight; Heidi Stirrup, Health Policy Coordinator; Josh Trent, Professional Staff Member, Health; Traci Vitek, Detailee, HHS; Ziky Ababiya, Democratic Policy Analyst; Jeff Carroll, Democratic Staff Director; Eric Flamm, Democratic FDA Detailee; Hannah Green, Democratic Public Health Analyst; Tiffany Guarascio, Democratic Deputy Staff Director and Chief Health Advisor; Rachel Pryor, Democratic Health Policy Advisor; Tim Robinson, Democratic Chief Counsel; and Arielle Woronoff, Democratic Health Counsel.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. Chair will recognize himself for an opening statement.

I would like to thank Secretary Burwell for appearing before the subcommittee to discuss the Administration's fiscal year 2016

budget request for the Department of Health and Human Services. Earlier this year, Madam Secretary, you stated that, "The hallmark of effective leadership is instilling a culture of transparency, ownership, and accountability." These are all laudable goals, and I appreciate your verbal commitment to these principles, however, your department's actions have failed to adhere to the same standard. For example, we have only heard silence from the White House on how the Administration is preparing for an adverse ruling in King v. Burwell. We did receive a reply from you, and I thank you for that courtesy.

But your letter contained no substantive answers to our questions. During your testimony to the Senate Finance Committee you were again asked about the Administration's plans, and again you repeatedly declined to provide a direct answer. And this is not the transparency that we had hoped for. Understandably, we were very frustrated with the Administration witnesses artfully dodging the questions that we ask here. So I am asking you today, please let your guard down a little, and give us direct and complete answers to our questions.

In 2009 the President correctly said, "The real problem with our long term deficit actually has to do with our entitlement obligations." Since then we have had the Simpson-Bowles Commission, a super-committee, sequestration, and a government shutdown, and never once in all this time did the Administration propose a plan to get the Nation's fiscal house in order by recommending reforms to entitlements. The 2014 Medicare Trustees' Report, which you signed, tells us that Medicare will be bankrupt very soon. We recently had Senator Joe Lieberman and former OMB Director Alice Rivlin here, and they told us much the same. And we stand ready to do the hard work of saving and strengthening Medicare, but we need a willing partner.

Once again, the President's budget fails to propose serious entitlement reform. The proposals in the budget related to Medicaid amount to saving just 15 days' worth of program spending over the next 10 years. The plan, apparently, is to let Medicare expenditures continue to grow without any of the structural reforms needed to strengthen and save this critical program, and this is not taking ownership. If we are going to save and strengthen our safety net programs for the most vulnerable, we have to do better than the President's budget. Both parties have to work together. You, we, the President need to work together to save our entitlement programs, make them sustainable, so we ask that you please work with us.

On another subject, you may also remember that in early November of last year we spoke on the phone about why HHS has so far failed to hold California accountable under Federal law. As you know, on August 22, 2014 the California Department of Managed Health care, DMHC, issued a directive mandating that all plans under DMHC authority immediately include coverage for all legal abortions. This is in direct violation of the Weldon Amendment, a civil rights statute that prohibits Federal taxpayer funding for Federal agencies and state or local governments that discriminate because a health care entity does not pay for or provide coverage of, or refer for abortions.

What California is doing is clearly illegal. It is also morally wrong, and violates the fundamental principles of freedom and conscience that our democracy is founded on, and it is your job to stop them, and so for that hasn't happened. So I will have more to say about this when we get to the questions.

In the meantime, Madam Secretary, we look forward to your testimony. We hope that you will stay to answer all of our questions. And, with only 5 minutes of questions per member, we respectfully ask that you keep your answers concise and to the point.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

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Thank you, and I yield the remainder of my time to Rep. _____.

Mr. PITTS. And, Dr. Burgess, do you want the remaining time?

Mr. BURGESS. Thank you, Mr. Chairman, that is very kind of you. And, Secretary, thank you for coming to our humble little subcommittee. I am frustrated over the Administration's lack of transparency, and the ability for Congress to get information that, realistically, we have been asking for for the last 4 or 5 years, but specifically around ACA created entities, the Center for Medicare and Medicaid Innovation, the Prevention and Public Health Fund, the Consumer—the Office of Consumer Information and Insurance Oversight, and the Patient Center for Outcomes and Research Initiative. Year after year they have failed to achieve their mission of reducing health care costs and improving quality. We can't hold them accountable if we don't know how you are spending the dollars. So you and I have talked about this, and I do look forward to your responses and being able to finally get that information regarding those agencies under your——

Mr. PITTS. Chair thanks the gentleman. Now recognize the Ranking Member, Mr. Green, 5 minutes for opening statement.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Good morning, and thank you, Secretary Burwell, for being here today to discuss the President's FY '16 budget proposal for the Department of Health and Human Services. A budget is more than a line of items on a page. It is a reflection of the priorities of our country. Our commitment must be to protect the progress that we made, and to make strategic investments so that progress will continue in the future.

This year marks the 50th anniversary of the creation of Medicare and Medicaid. Since the Children's Health Insurance Program was created to ensure America's children have insurance, most recently Congress passed the Affordable Care Act, dramatically expanding access to health coverage and high quality care. The Affordable Care Act took historic—steps toward laying the foundation for a better and more efficient health care system, and expanding access to cover for millions of Americans for whom it was previously out of reach. It also took important steps to restore the fiscal solvency of our health care system. According to the most recent estimates by the Congressional Budget Office, the Affordable Care Act will reduce the deficit by more than $100 billion for the first decade, and by more than a trillion in the second decade.

As we have seen through the second enrollment period, the Affordable Care Act has already succeeded in ensuring every American can have access to high quality affordable coverage. Thanks to the ACA, nearly 30 million Americans got covered. These are peo-

ple who would otherwise be uninsured. We have made great progress, but the work is not done. I thank the agency for implementing the landmark health reform law, and continuing to work with us so that we can build on these successes.

In addition to prioritizing essential services and programs, I was pleased to see that the budget makes strategic investments to improve our health care system, and clear the way for the progress into the future. This includes funding to support training of the next generation of health care providers, national preparedness against threats to public health, biomedical research, drug safety, and mental health services. The budget invests in community health centers to support the care they provide for 22 million patients. In their role of providing an accessible, reliable source of primary care in underserved communities, health centers will continue to be a critical element of our health system.

The President's proposal takes a critical important step by including four years of funding for the Children's Health care Insurance Program. Currently more than 10 million children get health insurance through CHIP. Additional funding for CHIP must be authorized so that there is no disruption in coverage, and the states are able to continue operating their programs. The budget proposes an increase in NIH funding. Since its creation, NIH has fostered remarkable advancements in human health, but for the past decade NIH has suffered inadequate funding. Without significant funding increases, the U.S. will lose its status as a global leader in science and innovation. Additional resources will help defeat our Nation's most harmful diseases, and ensure that the United States continues to lead biomedical research and scientific breakthroughs.

The budget proposal strengthens national preparedness for threats to public health, including naturally occurring threats, and deliberate attacks. It also includes funding to reinforce our Nation's ability to move quickly to detect infectious disease outbreaks through new advanced molecular detection initiative, maintaining strong expertise at the Centers of Disease Control and Prevention. These are just a few highlights of what is included in the proposed HHS budget. I look forward to hearing more about the Administration's proposal during today's hearing.

Thank you, Madam Secretary, for joining the committee to discuss the HHS budget. And if someone would like about a minute and 20 seconds? My colleague from California, Ms. Matsui.

Ms. MATSUI. Thank you very much for yielding the time, and welcome, Secretary Burwell. I appreciate the goals the President and you have laid forth in the fiscal budget 2016 Department of HHS Services Budget. Building on the improvements made by the Affordable Care Act, we are seeking to move our Nation's health system by rewarding volume, and forgetting about the waste business. So—do this is working to achieve the triple aim in health care, better care, better outcomes, and reduced costs. We do this by making health insurance more affordable, by emphasizing prevention and public health, by encouraging scientific and clinical research, by taking advantage of the benefits of technology, and building up our Nation's mental health system.

Many of the proposals in the budget find savings in the Medicare and Medicaid programs by streamlining processes and realigning

systems to ensure that patients get the right service at the right time. The budget would make the SGR fix permanent, which we need to do to provide stability for doctors, and for seniors, and people with disabilities in the Medicare program. The budget would also extend the Children's Health Insurance Program, or CHIP, that provides much needed pediatric coverage to our Nation's children.

To conclude, I want to emphasize the Affordable Care Act is working. Over 11 million Americans signed up this year, including 500,000 in California alone. The Administration just announced that since the law was enacted in 2010, 9.4 million people with Medicare have saved over $15 billion in prescription drugs. This is what we set out to do, and I appreciate working with you as we move forward. Thank you. Yield back.

Mr. PITTS. Gentlelady yields back. Chair now recognizes Chairman of the full Committee, Mr. Upton, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Well, thank you, Mr. Chairman. Secretary Burwell, welcome. Today marks your first official appearance before the Health Subcommittee, but I know that this is not your first time in this room, as you participated in one of our 21st Century Cures roundtables last year, and we very much appreciate that participation.

Your testimony does come at a very pivotal point in health policy, from our exciting cures effort, to next week's Supreme Court oral arguments. We look forward to hearing the Administration's perspective on the many important issues facing the American people. You have said during your tenure at HHS that transparency, ownership, and accountability are important values for the Department of demonstrate, which we certainly welcome.

In that spirit, we look forward to gaining straightforward answers here today about implementation of the President's health care law. There have been quite a few red flags raised in recent weeks on the continued struggles to implement key pieces of that health law. Just in the last week, 800,000 households learned that key tax forms sent out by the Administration contained major errors. Those Americans were asked to delay tax filing, therefore also delaying their refunds. A recent analysis from H&R Block estimates that the majority of Obamacare customers are being forced to pay back some of those subsidies. Millions of Americans are also learning about the law's IRS fines for failing to comply with the individual mandate.

The backlash has been so intense that the Administration has resorted to yet another special enrollment period to quell some of the anger of those who are just coming to learn about the individual mandate penalty. In this last week, the healthcare.gov CEO, Kevin Counihan, suggested that the backend functions of the exchange would undergo a 2-year development plan. That means that this key part of the law will not be fully complete until President Obama leaves the White House.

Collectively, these revelations suggest that the health care law is still not working. Our constituents deserve better, we know that. That is why I have worked on introducing the Patient Care Act, a health care reform blueprint, with my colleagues in the Senate, Chairman Hatch and Mr. Burr. I look forward to working with my colleagues about these ideas to improve health care in America by empowering states and families, not Washington.

Yes, we have concerns with the President's signature law, but there are other important health care areas that we believe are fertile for collaboration. For the past year, almost year and a half, this committee has undertaken the bipartisan 21st Century Cures Initiative to accelerate the pace of the discovery, development, and delivery of new treatments and cures for American patients.

I would like to thank you for your personal engagement on the 21st Century Cures Initiative. As you know, this is a top priority for our committee this year. Patients and families in my district in Michigan, as well as across the country are looking for hope, and that is what we seek to instill. And this effort is also important to many job creators, whether it be Stryker, Perrigo, or Pfizer in southwest Michigan. I also want to thank the staff throughout the administration, particularly at the FDA and the NIH for their work, their time, and effort to help us improve the ideas released by our committee at the end of last month. We have established a very good foundation, I think, for bipartisan success. And I will yield to other Republican members on this side. Seeing none——

Mr. PITTS. Anyone seeking time?

Mr. UPTON [continuing]. Yield back.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Secretary Burwell, welcome. Today marks your first official appearance before the Health Subcommittee—but I know it isn't your first time this room as you participated in one of our 21st Century Cures roundtables last year. Your testimony today comes at a pivotal point in health policy, from our exciting cures effort to next week's Supreme Court oral arguments. We look forward to hearing the administration's perspective on the many important issues facing the American people. You have said that during your tenure at HHS, transparency, ownership, and accountability are important values for the department to demonstrate, which we welcome.

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Millions of Americans are also now learning about the law's IRS fines for failing to comply with the individual mandate. The backlash has been so intense that the administration has resorted to yet another "special enrollment period" to quell some of the anger of those who are just coming to learn about the individual mandate penalty.

And this week, the HealthCare,gov CEO Kevin Counihan suggested that the back-end functions of the exchanges would undergo a two-year development plan. That means this key part of the law will not be fully complete until President Obama leaves the White House.

Collectively, these revelations suggest that the health care law is still not working. Our constituents deserve better. That is why I have worked on introducing the Patient CARE Act, a health care reform blueprint with my colleagues in the Senate,

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Mr. PITTS. The Chair thanks the gentleman, and now recognizes the Ranking Member of the full Committee, Mr. Pallone, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Pitts, and welcome, Secretary Burwell. Thank you for being with us today. Today we are going to hear about the President's fiscal year 2016 Health and Human Services budget proposal, and there are many important provisions in the President's budget that we in Congress must work to support. I was pleased to see that the budget proposed a funding increase of $1 billion for the NIH, investing in early stage basic research, is one of the most promising ways that we can accelerate the discovery of new treatments and cures. And support for NIH is critical to building our economy as well. Every dollar of NIH funding generates over $2 in local economic growth, yet we have let NIH purchasing power decline by over 20 percent since 2003, and that is why finding a way to significantly increase funding for NIH will be my top priority, as the 21st Century Cures Initiative continues.

I was also pleased to see that the budget fully funds a 4-year extension of the Children Health Insurance Program, or CHIP. We must act on this proposal immediately. With more than 4/5 of state legislatures adjourning the by the end of June, lack of action and clarify from Congress will make budgeting and planning virtually impossible. By every measure, CHIP has become enormously successful, and always has had strong bipartisan support, so extending CHIP funding should be the top priority of this committee to ensure consistent coverage for the millions of children who depend on this program. And I think we can all agree that no child should be left worse off because of the actions, or lack thereof, of Congress.

The budget also adopts the framework of the bipartisan, bicameral SGR repeal and replace legislation that Congress agreed to last year. I believe that because the Sustainable Growth Rate is the result of a budget gimmick, and we already spent $169 billion paying to fix the problem, that offsets, especially those within our health programs, are not necessary. And if we must include offsets, the war savings, which are known as the Overseas Contingency

Operation Funds, could be used. I know some on the other side of the aisle don't share this view. What I do hope is that we can agree that, first, SGR should not be paid off of the backs of the beneficiaries. Beneficiaries will already pay for their share of the cost of SGR repeal through higher premiums, and half of all beneficiaries live on less than $23,500.

And that is why some of the proposals in the President's budget concern me. The President's budget proposes to further increase Part B and Part D premiums, increase the Part B deductible for new enrollees, and impose a new surcharge on the Part B premium for beneficiaries with certain Medigap policies, and also institutes a $100 copayment per home health episode. And this increases out of pocket costs on beneficiaries, and I think that we have seen enough of that. Beneficiaries may forego necessary services, and, in result, use more high cost acute care services, and such policies will disproportionately affect lower and middle income beneficiaries who are not poor enough for Medicaid, nor have access to employer sponsored retiree health care. So I urge the President and my colleagues to be extremely cautious when proposing cuts to Medicare, and consider impacts on our seniors.

The last thing I wanted to mention is—well, first to commend you, Secretary, for your agency's hard work implementing the Affordable Care Act. Because of your efforts, 19 million uninsured Americans will be covered in this year, 2015. And I recognize the challenge your agency faces in implementing this law with limited resources, however, despite what I call Republican obstructionism, the Affordable Care Act is working.

In sum, I think this is a sound budget, and I look forward to hearing from you today. And I would yield the remainder of my time to the gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Well, I thank the Ranking Member for yielding time, and I welcome Secretary Burwell. We are very excited to hear about the budget, the investments in medical research and Children's Health Insurance, improvements in Medicare, and the Centers for Disease Control. But I couldn't help but ask Mr. Pallone for a minute to highlight the Florida enrollment numbers under the ACA. It is remarkable. And I know you have seen them, and we have talked about it. As of February 15, over 1.6 million Floridians have signed up for health insurance in the federally facilitated marketplace. We are surprised. This exceeded all of our expectations, to beat California and Texas, especially in a state that had many fits and starts over whether to assist our neighbors in signing up.

But I wanted to highlight a couple of stories. A 27-year-old third year law student at the University of South Florida got assistance from a navigator. His income is about $16,000 a year in scholarships. He was able to find insurance for approximately $10 per month, zero deductible. It is his second year enrolling in the marketplace. He is very happy with his coverage. There are stories like that again, and again, and again, so I look forward to talking about it. Thank you.

Mr. PITTS. Gentlelady yields back. That concludes the oral opening statements. As usual, all the written opening statements of the members will be made a part of the record. And so we will go now

to Secretary Burwell. First of all, thank you for appearing before us today, Madam Secretary. Your written testimony will be made a part of the record. You will be given 5 minutes to summarize your testimony, and we certainly appreciate you being here this morning. And you are recognized for 5 minutes for your summary.

STATEMENT OF THE HONORABLE SYLVIA MATHEWS BURWELL, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary BURWELL. Thank you Chairman Pitts, Chairman Upton, Ranking Member Pallone, and Ranking Member Green, and members of the committee. I appreciate the invitation to be here today. I want to thank you for the opportunity to discuss the President's budget for the Department of Health and Human Services.

I believe firmly that we all share common interests, and therefore we have a number of opportunities for common ground, from preventing and treating substance abuse, to advancing the promise of precision medicine, to building an innovation economy, and strengthening the American middle class. The budget before you makes critical investments in health care, science, innovation, and human services. It maintains our responsible stewardship of the taxpayers' dollars. It strengthens our work together with the Congress to prepare our Nation for key challenges, both at home and abroad.

For HHS, it proposes $83.8 billion in discretionary budget authority, and this is a $4.8 billion increase, which will allow our department to deliver impact today, and lay a strong foundation for tomorrow. It is a fiscally responsible budget, which, in tandem with accompanying legislative proposals, would save taxpayers a net estimated $250 billion over the next decade. In addition, it is projected to continue slowing the growth of Medicare. It could secure 423 billion in savings as we build a smarter, healthier, better system.

In terms of providing all Americans with access to quality, affordable health care, it builds upon our historic progress in reducing the number of uninsured, and improving coverage for families who already have insurance. We saw a recent example of this progress with the about 11.4 million Americans who either signed up or re-enrolled in this past open enrollment. It extends CHIP for 4 years, it covers newly eligible adults in the 28 states, plus D.C., which have expanded Medicaid, and it improves access to health for Native Americans. To support communities throughout the country, including underserved communities, it invests $4.2 billion in health centers, and $14.12 billion to bolster our Nation's health workforce. It is more than 50,000 National Health Service Corps clinicians, serving nearly 16 million patients in high need areas across the country. With health center mandatory funding ending in 2016, we estimate that more than seven million Americans may lose access to essential cost-effective primary care, and this could approximately result in 40,000 jobs lost.

To advance our common interests in building a better, smarter, healthier delivery system, the budget supports improvements to the way care is delivered, providers are paid, and information is distributed. On an issue for which there is bipartisan agreement,

it replaces Medicare's flawed sustainable growth rate formula, and supports a long term policy solution to fix the SGR. The Administration supports the type of bipartisan, bicameral efforts that the Congress took last year.

To advance our shared vision for leading the world in science and innovation, it increases funding for the NIH by a billion dollars to advance biomedical and behavioral research. In addition, it invests 250 million for the Precision Medicine Initiative, an effort to focus on developing treatments, diagnostics, and prevention strategies tailored to individual genetic characteristics. To further our common interests in providing Americans with the building blocks for success at every stage of life, this budget outlines an ambitious plan to make affordable quality child care available to every working class—middle class family.

To keep Americans health, the budget strengthens our public health infrastructure, with $975 million for domestic and international preparedness, including critical funds to the Global Health Security Agenda. The budget will support CDC's critical infrastructure and cost-cutting research to facilitate rapid response to public health emergencies, and other public health threats, like the recent measles outbreak. It also invests in behavioral health sciences, and substance use prevention. Finally, as we look to leave our department stronger, the budget invests in our shared priorities of cracking down on waste, fraud, and abuse initiatives, and are projected to yield $22 billion in gross savings for Medicare. We are also addressing our Medicare appeals backlog with a variety of approaches, and we are investing in cybersecurity.

As a close, I want to make one final point, and that is I am personally committed to responding quickly and thoughtfully to the concerns of Congress and members. Since I was confirmed, I have made it the top priority of our department to respond promptly and thoroughly, and work with you as we can. I also just want to take one moment to thank the HHS employees for all their work on Ebola, unaccompanied children, and all the other issues. With that, I look forward to your questions. Thank you.

[The prepared statement of Secretary Burwell follows:]

Statement by
Sylvia M. Burwell
Secretary
U.S. Department of Health and Human Services
on
The President's Fiscal Year 2016 Budget
before
Committee on Energy and Commerce Subcommittee on Health
United States House of Representatives

Thursday, February 26, 2015

Chairman Pitts, Ranking Member Green, Chairman Upton, Ranking Member Pallone and Members of the Committee, thank you for the opportunity to discuss the President's FY 2016 Budget for the Department of Health and Human Services (HHS).

The Department has made historic strides towards ensuring that all Americans can lead healthy and productive lives. Today, thanks to the Affordable Care Act (ACA), middle class families have more security, and many of those who already had insurance now have better coverage. In the past year alone, about 10 million uninsured Americans finally gained health insurance. In the private market, millions more now have access to expanded coverage for preventive health care services, such as a mammogram or flu shot, without cost sharing. At the same time, as a nation we are spending our health care dollars more wisely and starting to receive higher quality care.

In part due to the ACA, households, businesses, and the Federal Government are now seeing substantial savings. Today, health care cost growth is at exceptionally low levels, and premiums for employer sponsored health insurance are about $1,800 lower per family on average than they would have been had trends over the decade that preceded the ACA continued. Across the

board, the Department has continued its commitment to the responsible stewardship of taxpayer dollars through investments in critical management priorities. We have strengthened our ability to combat fraud and abuse and advance program integrity, further driving savings for the taxpayer while enhancing the efficiency and effectiveness of our programs.

The Department has done important work addressing historic challenges, including the coordinated whole-of-government responses to Ebola both here at home and abroad and to last year's increase in unaccompanied children crossing the Southwest border into Texas.

The President's FY 2016 Budget for HHS builds on this progress through critical investments in health care, science and innovation, and human services. The Budget proposes $83.8 billion in discretionary budget authority, an increase of $4.8 billion from FY 2015 appropriations. This additional funding will allow the Department to make the investments that are necessary to serve the millions of American people who count on our services every day, while laying the foundation for healthier communities and a stronger economy for the middle class in the years to come. The Budget also further strengthens the infrastructure needed to prevent, prepare for, and respond to future challenges effectively and expeditiously.

The Department's Budget request recognizes our continued commitment to balancing priorities within a constrained budget environment through legislative proposals that, taken together, would save the American people a net estimated $228.2 billion in HHS programs over 10 years. The Budget builds on savings and reforms in the ACA with additional measures to strengthen Medicare and Medicaid, and to continue the historic slow-down in health care cost growth.

Medicare proposals in our Budget, for example, more closely align payments with the costs of providing care, encourage health care providers to deliver better care and better outcomes for their patients, improve access to care, and create incentives for beneficiaries to seek high value services.

Providing all Americans with Access to Quality, Affordable Health Care

The President's FY 2016 Budget request builds on progress made to date by focusing on access, affordability, and quality – goals that we share with Congress and hope to work on together, in partnership, moving forward. The Budget also continues to make investments in Federal public health and safety net programs to help individuals without coverage get the medical services they need, while strengthening local economies.

Expanding Options for Consumers through the Health Insurance Marketplaces. The ACA is making quality, affordable health coverage available to millions of Americans who would otherwise be uninsured. As of mid-February about 11.4 million consumers selected a plan or were automatically re-enrolled through the Health Insurance Marketplaces for coverage in 2015. At the same time, consumers are seeing more choice and competition. There are over 25 percent more issuers participating in the Marketplace in 2015 compared to 2014. Not only that, in 2015, nearly 8 in 10 Federal Marketplace customers can get coverage for $100 or less per month after applicable tax credits.

Partnering with States to Expand Medicaid for Low-Income Adults. The ACA provides full Federal funding to cover newly eligible adults in states that expand Medicaid up to 133 percent

of the Federal poverty level through 2016, and covers no less than 90 percent of costs thereafter. This increased Federal support has enabled 28 states and the District of Columbia to expand Medicaid coverage to more low-income adults. Just recently we saw another state, Indiana, join us to bring much needed access to health care coverage to a state-estimated 350,000 uninsured low-income residents. Across the country, as of November 2014, over 10.1 million additional individuals are now enrolled in Medicaid and CHIP compared to the fall of 2013. As Secretary, I am personally committed to working with Governors across all 50 states to expand Medicaid in ways that work for their states, while protecting the integrity of the program and those it serves.

Extending the Children's Health Insurance Program. The Budget includes an additional four years of funding for CHIP through FY 2019 to provide comprehensive and affordable coverage for children and families across the United States. This extension will help bring stability to state budgets and continuity of coverage for children. We believe there is bipartisan support for CHIP and look forward to working with Congress to extend this program for the millions of children who depend upon it.

Improving Access to Health Care for American Indians and Alaska Natives (AI/AN). Reflecting the President's commitment to improving health outcomes across tribal nations, the Budget includes $6.4 billion for the Indian Health Service to strengthen programs that serve over 2.2 million American Indians and Alaska Natives at over 650 health care facilities across the United States. The request fully funds estimated Contract Support Costs in FY 2016 and proposes to modify the program in FY 2017 by reclassifying it as a mandatory appropriation, creating a longer-term solution.

Bolstering the Nation's Health Workforce. The Budget includes a $14.2 billion investment in our Nation's health care workforce to improve access to healthcare services, particularly in rural and other underserved communities. That includes support for over 15,000 National Health Service Corps clinicians, who will serve the primary care, mental health, and dental needs of nearly 16 million patients in high-need areas across the country. The Budget also creates new funding for graduate medical education in primary care and other high-need specialties, which will support more than 13,000 residents over 10 years, and advance the Administration's goal of higher-value healthcare that reduces long-term costs.

To continue encouraging provider participation in Medicaid, the Budget invests $6.3 billion to extend the enhanced Medicaid reimbursement rate for primary care services, and makes strategic investments to encourage primary care by expanding eligibility to obstetricians, gynecologists, and non-physician practitioners. A January 2015 study by University of Pennsylvania and Urban Institute researchers found that the share of Medicaid enrollees who successfully got appointments with primary care providers grew by nearly 8 percentage points between 2012 and 2014, when the program was fully implemented. The Budget also supports the provision of primary care services in the Medicare program by permanently incorporating the temporary 10 percent primary care incentive payment program into the Medicare physician fee schedule.

Investing in Health Centers. Health centers are an essential primary care provider for America's most vulnerable populations, serving 1 out of every 15 Americans while reducing the use of costlier care through emergency departments and hospitals. The Budget includes $4.2 billion for health centers, including $2.7 billion in mandatory resources, to serve

approximately 28.6 million patients in FY 2016 at more than 9,000 sites in medically underserved communities throughout the country.

The Department's requests for health centers and the National Health Service Corps are vitally important, as the existing mandatory funding streams for these programs end in 2015. Without renewed funding in 2016 and beyond, we estimate that more than 7 million Americans would lose access to essential cost-effective primary care services provided through our Nation's health centers and approximately 40,000 jobs would be lost. Further, efforts to ensure provider access in underserved rural and urban areas across the country through the National Health Service Corps will come to a halt.

Delivering Better Care and Spending our Health Care Dollars Wisely

If we find better ways to deliver care, pay providers, and distribute information, we can receive better care and spend our dollars more wisely, all the while supporting healthier communities and a stronger economy. To build on and drive progress on these priorities, we are focused on the following three key areas:

Improving the Way Care is Delivered. The Administration is focused on improving the coordination and integration of health care, engaging patients more fully in decision-making, and improving the health of patients – with an emphasis on prevention and wellness. HHS believes that incentivizing the provision of preventive and primary care services will improve the health and wellbeing of patients and slow cost growth over the long run through avoided hospitalizations and additional office visits. The Administration's efforts around patient safety

and quality have made a difference – we have seen hospital readmissions in Medicare fall by nearly eight percent, translating into 150,000 fewer readmissions between January 2012 and December 2013 and hospital patient harm measures fall by 17 percent from 2010 to 2013, which, according to preliminary estimates, may be associated with saving 50,000 lives and $12 billion in health spending.

Improving the Way Providers are Paid. The Administration is testing and implementing new payment models that reward value and care coordination – rather than volume. HHS has seen promising results on cost savings with alternative payment models: already, existing Accountable Care Organizations (ACOs) programs have generated combined total program savings of $417 million to Medicare. To shift Medicare reimbursement from volume to value, and further drive progress in the health care system at large, the Department has announced its goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models by 2016 and 50 percent by 2018.

The Budget supports progress in this area by including proposals targeted at changing provider incentives and payment mechanisms. For example, the Budget puts Medicare's payments to physicians on solid ground by replacing Medicare's flawed Sustainable Growth Rate formula. The Budget would establish new annual physician payment updates to provide certainty and consistency to providers; create incentives for providers to participate in proven alternative payment models; and streamline other value-based incentives. The Administration supports a long-term policy solution to fix the SGR and applauds the bipartisan, bicameral efforts that

Congress undertook last year. The Administration looks forward to working with Congress to build on that effort and reform Medicare physician payments in a fiscally responsible manner.

Improving the Way Information is Distributed. The Administration is working to create transparency of cost and quality information and to bring electronic health information to the point of care – enabling patients and providers to make the right decisions at the right time to improve health and care. The Centers for Medicare & Medicaid Services (CMS) is making major strides to expand and improve its provider compare websites, which empower consumers with information to make more informed health care decisions, encourage providers to strive for higher levels of quality, and drive overall health system improvement. To improve communication and enhance care coordination for patients, the FY 2016 Budget also includes a substantial investment ($92 million) in efforts supporting the adoption, interoperability, and meaningful use of electronic health records.

Leading the World in Science and Innovation

Investments in science and innovation have reshaped our understanding of health and disease, advanced life-saving vaccines and treatments, and helped millions of Americans live longer, healthier lives. With the support of Congress, there is more that we can do together. The President's FY 2016 Budget request lays the foundation to maintain our Nation's global edge in medical research. This Budget for NIH supports ongoing research and provides real investments in innovative science.

Advancing Precision Medicine. The FY 2016 Budget includes $215 million for the Precision Medicine Initiative, a new cross-Department effort focused on developing treatments, diagnostics, and prevention strategies tailored to the genetic characteristics of individual patients. This effort includes $200 million for the National Institutes of Health (NIH) to launch a national research cohort of a million or more Americans who volunteer to share their information, including genetic, clinical and other data to improve research, as well as to invest in expanding current cancer genomics research, and initiating new studies on how a tumor's DNA can inform prognosis and treatment choices. The Department will also modernize the regulatory framework to aid the development and use of molecular diagnostics, and develop technology and define standards to enable the exchange of data, while ensuring that appropriate privacy protections are in place. With the support of Congress, this funding would allow the Department to scale up the initial successes we have seen to date and bring us closer to curing the chronic and terminal diseases that impact millions of Americans across the country.

Supporting Biomedical Research. The FY 2016 Budget includes $31.3 billion for NIH, an increase of $1 billion over FY 2015, to advance basic biomedical and behavioral research, harness data and technology for real-world health outcomes, and prepare a diverse and talented biomedical research workforce. This research is critical to maintaining our country's leadership in the innovation economy, and can result in life-changing breakthroughs for patients and communities. For example, that NIH estimates it will be able to spend $638 million under this Budget request on Alzheimer's research, an increase of $51 million over FY 2015, which will position us to drive progress on recent advances in our understanding of the genetics and biology of the disease, including drugs currently in clinical trials, and those still in the pipeline.

Addressing Alzheimer's Disease. Over 5 million Americans have Alzheimer's disease today, and dementia costs the nation approximately $200 billion per year in health costs – and those numbers are projected to rise steadily as the population ages. Recent advances in our understanding of the genetics and biology of Alzheimer's have identified new potential targets for innovative therapies to slow and ultimately prevent this devastating disease. NIH estimates it will spend $638 million on Alzheimer's research in FY 2016, an increase of $51 million over FY 2015 to implement the research components of the *National Plan to Address Alzheimer's Disease*, a roadmap to assist in meeting the goal to prevent and effectively treat Alzheimer's by 2025. The FY 2016 budget includes provisions, supported by my Advisory Council on Alzheimer's disease, to provide important supports to individuals with dementia and the family members who help care for them.

Ensuring the Building Blocks for Success at Every Stage of Life

As part of the President's plan to bolster and expand the middle class, the Budget includes a number of proposals that help working Americans meet the needs of their families – including young children and aging parents.

Investing in Early Learning. High-quality early learning opportunities both promote children's healthy development and support parents who are balancing work and family obligations. Across the United States, many American families face real difficulties finding and affording quality child care and early education. In 2013, the average cost of full-time care for an infant at a child care center was about $10,000 per year – higher than the average cost of in-state tuition and fees at a public 4-year college. The Budget outlines an ambitious plan to make affordable,

quality child care available to every low-income and middle-class family with young children; to expand access to high-quality early learning opportunities through the Head Start and Early Head Start programs; and to invest in voluntary, evidence-based home visiting programs that have been shown to leave long-lasting, positive impacts on parenting skills, children's development, and school readiness. These investments complement proposals at the Department of Education to provide high-quality Preschool to all four year olds from low- and moderate-income families and expand programs for middle-class children as well.

The President's child care proposal builds on the reforms passed by Congress in the bipartisan reauthorization of the Child Care and Development Block Grant enacted last fall. The proposal would expand access to more than 1 million additional children through the Child Care and Development Fund (CCDF) and provides resources to help states improve quality and design programs that better serve families facing unique challenges in finding quality care, such as those in rural areas or working non-traditional hours.

The Budget also proposes $15 billion over ten years to extend and expand access to evidence-based home visiting programs building on research showing that home visits by a nurse, social worker, or other professional during pregnancy and in the early years of life can significantly reduce child abuse and neglect, improve parenting, and promote child development and school readiness.

Research by the President's Council of Economic Advisors indicates that investments in high-quality early education generate economic returns of over $8 for every $1 spent. Not only that,

studies show high-quality early learning programs result in better outcomes for children across the board – with children more likely to do well in school, find good jobs and greater earnings, and have fewer interactions with the criminal justice system. These programs also strengthen parents' abilities to go to work, advance their career, and increase their earnings. That is why the Administration has outlined a series of measures, including tax cuts for working families, to advance our focus on improving quality, while also dramatically expanding access.

Supporting Older Adults. The number of older Americans age 65 and older with severe disabilities – defined as 3 or more limitations in activities of daily living – that are at greatest risk of nursing home admission, is projected to increase by more than 20 percent by the year 2020. With 2015 marking the year of the White House Conference on Aging, the Department's Budget request makes investments to address the needs of older Americans, many of whom require some level of assistance to continue living independently or semi-independently within their communities. The Budget includes common-sense reforms that help to protect older Americans from identity theft, while supporting family caregivers and expanding options for home and community-based services and supports.

Improving Child Welfare. The Department's Budget also proposes several improvements to child welfare programs that serve children who have been abused and neglected or are at risk of maltreatment. The Budget includes a proposal that has generated bipartisan interest that would provide $750 million over five years for an innovative collaboration between the Administration for Children and Families (ACF) and CMS that would assist states to provide evidence-based interventions to youth in the foster care system to reduce the over-prescription of psychotropic

medications. There is an urgent need for action: ACF data show that 18 percent of the approximately 400,000 children in foster care were taking one or more psychotropic medications at the time they were surveyed.

Keeping Americans Healthy

The President's FY 2016 Budget strengthens our public health infrastructure, invests in behavioral health services, and prioritizes other critical health issues.

Investing in Domestic and International Public Health Preparedness. The health of people overseas directly affects America's safety and prosperity, with far-reaching implications for economic security, trade, the stability of foreign governments, and the well-being of U.S. citizens abroad and at home. The Budget includes $975 million for domestic and international public health preparedness infrastructure, including an increase of $12 million for Global Health Security Agenda implementation to build the capacity for countries to detect and respond to potential disease outbreaks or public health emergencies and prevent the spread of disease across borders.

As new infectious diseases and public health threats emerge, HHS continues to invest in efforts to bolster the Nation's preparedness against chemical, biological, nuclear, and radiological threats. This includes a $391 million increase for Project BioShield to support procurements and replenishments of new and existing countermeasures and to advance final stage development of new products, and to replace expiring countermeasures and maintain current preparedness levels in the Strategic National Stockpile. In addition, the Budget will support CDC's critical

infrastructure and cross-cutting research to facilitate rapid response to public health emergencies and other public health threats, such as the ongoing measles outbreak. Among other activities, CDC directs public health response efforts; detects sources of disease outbreaks; and develops tests to rapidly detect biological, chemical, and radiological agents.

Combatting Antibiotic Resistant Bacteria. The Centers for Disease Control and Prevention estimates that each year at least two million illnesses and 23,000 deaths are caused by antibiotic-resistant bacteria in the United States alone. The Budget nearly doubles the amount of federal funding for combating and preventing antibiotic resistance within HHS to more than $990 million. This includes more than $650 million across the National Institutes of Health (NIH) and the Biomedical Advanced Research and Development Authority (BARDA) to significantly expand America's investments in development of antibacterial and new rapid diagnostics, and to launch a large-scale effort to characterize drug resistance. More than $280 million in funding for CDC will improve antibiotic stewardship; outbreak surveillance, antibiotic use and resistance monitoring, and research and development related to combating antibiotic resistance. And $47 million for the Food and Drug Administration (FDA) will support evaluation of new antibacterial drugs for patient treatments and antibiotic stewardship in animal agriculture.

Addressing Prescription Drug and Opioid Misuse and Abuse. The misuse and abuse of prescription drugs impacts the lives of millions of Americans across the country, and costs the American economy tens of billions of dollars in lost productivity and increased health care and criminal justice expenses. In 2009, total drug overdoses overtook every other cause of injury death in the United States, outnumbering fatalities from car crashes for the first time. In 2012

alone, 259 million opioid prescriptions were written – enough for every American adult to have a bottle. As part of a new, aggressive, multi-pronged initiative, the Budget includes more than $99 million in new funding in CDC, SAMHSA, ONC, and AHRQ to support targeted efforts to reduce the prevalence and impact of opioid use disorders. This initiative prioritizes activities backed by the best evidence available and the greatest opportunity for measurable impact. Preventing opioid misuse and abuse, including opioid-related overdoses and deaths, requires prevention, treatment, and recovery support services. The Budget addresses each of these key areas and provides funding to expand access to medication-assisted treatment for opioid addiction and to equip first responders with training and emergency medication used to rapidly reverse the effects of opioid overdoses. The Budget also includes improvements in Medicare and Medicaid, including a proposal to require states to track high prescribers and utilizers of prescription drugs in Medicaid, which would save $710 million over 10 years and bolster other efforts to reduce abuse of prescription drugs.

Improving Access to Mental Health Services. Mental and medical condition comorbidity results in decreased length and quality of life, and increased functional impairment and cost. Patients diagnosed with a serious mental illness die as much as 25 years earlier than other Americans, and they are also among the least likely to seek treatment. The Budget includes an increase of $35 million, a total of $151 million, within SAMHSA for the President's *Now is the Time* initiative to focus on prevention and treatment of mental health issues among students and young adults. Reaching 750,000 young people per year and training thousands of additional behavioral health professionals and paraprofessionals, this investment represents a substantial step toward reducing barriers for individuals seeking care. Additional funds will be used to increase workforce

capacity across the nation by expanding an existing partnership with HRSA that addresses the number of licensed behavioral health professionals available and by creating a Peer Professionals program to provide training for individuals who have lived through their own battle with behavioral health issues to help reach those in need of treatment. In addition, this increase will help change the attitudes of Americans about mental and substance use disorders and their willingness to seek help through a social media campaign and other outreach efforts. The Budget also supports ongoing research at the National Institutes of Mental Health to prevent the first break of serious mental illness and change the trajectory of these disorders. Finally, the Budget proposes the elimination of Medicare's 190-day lifetime limit on inpatient psychiatric facility services, removing one of the last obstacles to behavioral health parity in the Medicare benefit.

Leaving the Department Stronger

The FY 2016 Budget request positions the Department to most effectively fulfill our core mission by investing in a number of key management priorities that will strengthen our ability to combat fraud, waste, and abuse, strengthen program integrity, and enable ongoing cybersecurity efforts, among other areas.

Strengthening Program Integrity. The FY 2016 Budget continues to build on progress made by the Administration to eliminate excess payments and fraud. The Budget includes new investments in program integrity totaling $201 million in FY 2016 and $4.6 billion over ten years. This includes, for example, the continued funding of comprehensive efforts to combat health care fraud, waste, and abuse through prevention activities, improper payment reductions, provider education, audits and investigations, and enforcement through the full Health Care

Fraud and Abuse Control (HCFAC) discretionary cap adjustment. This investment builds on important gains over the course of the past several years: from 2009 to 2013, programs supported by HCFAC have returned over $19 billion in health care fraud related payments. Together, the Department's proposed program integrity investments will yield $22 billion in gross savings for Medicare and Medicaid over 10 years.

Reforming the Medicare Appeals Process. Between FY 2009 and FY 2014, the number of appeals received by the Office of Medicare Hearings and Appeals has increased by more than 1300%, which has led to a backlog that is projected to reach 1 million appeals by the end of FY 2015. The Department has undertaken a three-pronged strategy to improve the Medicare Appeals process: 1) Take administrative actions to reduce the number of pending appeals and prevent new cases from entering the system; 2) Request new resources to invest at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog; and 3) Propose legislative reforms that provide additional funding and new authorities to address the appeals volume. The FY 2016 Budget includes a comprehensive legislative package of seven proposals aimed both at helping HHS process a greater number of appeals and reducing the number of appeals filed and requests additional resources for CMS, OMHA, and the Departmental Appeals Board to enhance their capacity to process appeals.

Investing in Cybersecurity. As cyber threats continue to multiply and become more complex, it is critical for the U.S. government to ensure that its information systems are protected from any potential attacks. In FY 2016, HHS requests $73 million, $28 million above FY 2015, to manage and provide oversight to the Department's Cybersecurity Program. This investment is designed

to reinforce and protect the Department's information technology systems against the growing threats within the cyber community. This funding also supports the Department's ability to quickly respond to evolving security threats and to better support ongoing infrastructure upgrades. The Budget includes funding to support the continued expansion of the Cybersecurity Operations program, enabling the Department to better ascertain the overall security risk to its systems and ensure compliance with requirements of the Federal Information Security Management Act.

Protecting Unaccompanied Children. This past summer, the Administration responded to a significant increase in the number of unaccompanied children who were apprehended on the southwest border, with an aggressive, coordinated federal response focused on providing humanitarian care for the children as well as on stronger deterrence, enforcement, foreign cooperation, and capacity for federal agencies to ensure that our border remains secure. In part as a result of those actions, the number of unaccompanied children apprehended at the border in FY 2015 is below FY 2014 and the number of children referred to ACF is projected to stabilize. To ensure ACF can take custody of all referred children in FY 2016, the Budget includes $948 million in base funding and creates a contingency fund that would trigger additional funds if caseloads exceed levels that could be supported with base funding and any prior-year carryover.

Conclusion

Members of the Committee, thank you for the opportunity to testify today. The President's FY 2016 Budget request for HHS makes the investments critical for today while laying the foundation for a stronger economy for the middle class. I am looking forward to working closely

with Congress and Members of this Committee on these priorities moving forward so that together we can best deliver impact for those we serve – the American people. I welcome any questions you may have.

Mr. PITTS. Thank you, Madam Secretary. I will begin the questioning, and recognize myself for 5 minutes for that purpose.

Let me start with King v. Burwell. In a few short days, the Supreme Court will be hearing oral arguments in the King v. Burwell case that could have a major impact on Obamacare. In January we sent you a letter, asking for any actions, analysis, and/or contingency plans that HHS has undertaken to prepare if the IRS rule is overturned. And while we received a letter from you earlier this week, your response failed to actually answer our question. The letter simply stated that you believed no administrative action by HHS could reverse the effects of a decision in favor of the Plaintiffs.

Madam Secretary, your statement of opinion in the letter does not answer a simple question, so let me ask you the question this way. Have you or senior Department officials instructed counselors within HHS to prepare any potential actions or approaches if the Supreme Court rules against the IRS?

Secretary BURWELL. Mr. Chairman, with regard to what is in the letter, one of the things that I think is important to reflect that is in the letter is the analysis of what would happen. That is a part of the letter. And in terms of what would happen—and I first should state that we believe that the Court will decide in favor of the position we hold, which is we believe that this law says that—people have traveled across the country—people in Texas should have the same subsidies as people in New York. It is an important starting point.

But with regard to what would happen, because I think that is an important part of answering the question, first, what would happen is, when those subsidies go away, 11.4 million people, that was the number I gave you—as of January 30, when we did our most recent analysis, 87 percent of the individuals in the marketplace are eligible for subsidies. Those subsidies are, on average, estimated to be $268 per individual, per month. Those subsidies, number one, would go away.

Mr. PITTS. Yes.

Secretary BURWELL. That would lead to a number——

Mr. PITTS. Madam Secretary, I understand that. I am asking if you know of any plan to respond to approaches if the Supreme Court rules against the IRS? Has the White House, has OMB, or other Administration officials directed or asked you about any approaches in response to King v. Burwell, or to work with the Treasury Department on potential responses? That is my question.

Secretary BURWELL. So, in order to respond to the question, Mr. Chairman, in order to think about the question of a plan, one needs to, I think, analyze the problem, which is what I was articulating, in terms of the three major things that would occur if the Court decides with the Plaintiffs.

Mr. PITTS. Let me ask it a different way. I would like to provide you some more information as to why we expect an answer from you today. The Committee received recently specific information from a source within your department about the existence of an approximately 100-page document related to potential actions HHS may take if the Supreme Court rules against the Administration in

King v. Burwell. Are you, or senior staff at HHS, aware of this document?

Secretary BURWELL. Mr. Chairman, this is a document I am not aware of.

Mr. PITTS. OK.

Secretary BURWELL. With regard to the question that you have asked, as I said in the letter, we believe—and I think it is very important to understand the damage, because it is related to the answer. The damage comes in the number of uninsured that would occur. Number two, it occurs in what happens in the individual marketplace, where a group of less health individuals come in, and that drives premiums up in that marketplace. And, number three, the indigent care that occurs from the uninsured, and what that means in both those states, in terms of their economies, as well as what it means for employer base. Those are the ramifications. With regard to those things, which we believe are the damage, as I state in the letter, we believe we do not have any administrative actions, and, therefore, there is not——

Mr. PITTS. All right, let me go on to another issue. I, as you know, as we discussed over the phone, am deeply concerned about the lack of HHS action regarding California, and the DMHC authority to immediately include coverage for abortion. And this mandate, California mandate is a clear violation of the Weldon Amendment, which provides civil rights protections, and prohibits funding to government entities discriminating against health care entities for following their conscience. Do you agree that the Weldon Amendment prohibits funding for states that mandate abortion coverage in insurance plans?

Secretary BURWELL. We take the Weldon Amendment very seriously. And since you spoke with me, Mr. Chairman, and we received those letters, we have opened an investigation in the Office of Civil Rights at HHS to investigate the concerns that you and others have articulated. We take this seriously, and are trying to move through that investigation as expeditiously as possible.

Mr. PITTS. So since it is clear that California is in violation of Federal law, can you project a date by which you expect the violation to be stopped?

Secretary BURWELL. With regard to the issue of the investigation, Mr. Chairman, that is not something—I need to let the investigation go, and I have asked the team to make sure they do it as expeditiously as possible, but in order—that I stay away from the investigation, in terms of my interference in any way. I want to let them go forward, but I have asked for due speed.

Mr. PITTS. OK. We will follow up. Thank you. Chair recognizes the Ranking Member Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

Madam Secretary, it has been almost 5 years since the Affordable Care Act was passed, and have yet to see any legislation introduced by my Republican colleagues to replace the Affordable Care Act, even though we have had at least 56 votes on the House floor to repeal it. Given all this talk of repealing the Affordable Care Act, are you aware of any request for technical assistance from Republicans on legislation that would replace the Affordable Care Act

with a credible proposal to provide comprehensive health coverage to millions of Americans?

Secretary BURWELL. I am not aware of those requests.

Mr. GREEN. Madam Secretary, over the last couple days we have heard a lot about contingency plans. If the millions of Americans who received financial help through the Affordable Care Act would lose them, are you aware of any Republican legislative proposals that would provide millions of Americans with the financial assistance to help them with affordable health care coverage?

Secretary BURWELL. I am not aware.

Mr. GREEN. Secretary, I want to get your input on an issue that I know you are concerned—I appreciate you addressing it in your opening remarks, that myself, and a lot of members of our committee—there is a funding cliff that is facing our community health centers. Health centers serve nearly 22 million patients, and are projected to serve 28.6 million patients in over 9,000 locations across the country in the fiscal year of 2016. Because of the current patient demographics and statutory mandate to locate in underserved areas, or to serve underserved populations, health centers are well positioned to provide health care service to millions of newly insured Americans. They are particularly important in our district, which is a federally designated underserved community in Houston, Texas.

Secretary Burwell, I was pleased to see the President's budget included a multi-year extension of mandatory funding for health centers. As you know, the health centers patients face a major loss of access in a few months if we don't act to prevent the funding cliff caused by the expiration of the mandatory funding at the end of the fiscal year. Can you speak about the importance of community health centers within our health system as we look at the issues of access, quality, and cost?

Secretary BURWELL. We believe that they are a fundamental underpinning, and not just in terms of health care in communities, but they are also an important part of the economics of communities, when you think about the fact that we could lose up to 40,000 estimated jobs in terms of who we don't extend. But as you think about the numbers, thinking that 1 in 15 Americans actually are served by these health centers, how integral they are to providing primary care throughout the country.

And so we think it is extremely important to continue that so that we can—as we have reduced the number of uninsured, we also want to make sure that those people are having care, and those that had care before still have access to that care, especially in our underserved communities across the country, not all, but many of which are very rural.

Mr. GREEN. Can you comment on the impact that the funding cuts would have on patients' access to care? Can you estimate how many fewer people would be able to receive services at our local health centers?

Secretary BURWELL. Our estimates are that if we aren't able to extend, that it could be up to seven million patients who would no longer be able to have access to that care. We estimate that perhaps over 2,000 of the centers would shut down without that, and that—then there are the patients who would not be served because

people would have to scale back in a number of the centers with reduced funding.

Mr. GREEN. In those 2,000 centers, do you know how many jobs we lost?

Secretary BURWELL. Approximately—the estimates are up to 40,000.

Mr. GREEN. OK. Thank you. The health centers are a crucial part of our Nation's primary care infrastructure for 50 years, and have long had truly bipartisan support. In the last year, along with my colleagues on both sides, including Representative Lance, support—reiterating our support for health centers, and calling for a bipartisan solution, we had 250 co-signers, including 31 members of our committee. A similar letter in the Senate gathered 60—gained 66 votes, and more than 100 national organizations have called for a fix. Consensus is something must be done, and we have to act as soon as possible.

This issue is a top priority of mine, and I know a lot of other members, literally, Republican and Democrat across the country, who look forward to working with you and our colleagues on the committee on a bipartisan basis to find a solution to avert that funding cliff.

Mr. Chairman, I have 43 seconds left, and I would like to yield for somebody for that 43 seconds on our side. Anybody want about 30 seconds now? OK. Well, Mr. Chairman, I yield back.

Mr. PITTS. Thank you. Chair now recognizes the Chairman of the full Committee, Mr. Upton, 5 minutes for questions.

Mr. UPTON. Thank you again, Mr. Chairman. Secretary Burwell, there are a number of health care law implementation issues that continue to trouble us. In the interest of time, I would ask that you submit answers to the following questions in writing within 2 weeks.

The CEO of healthcare.gov recently stated that there is a 2 year development plan for the backend of the healthcare.gov. If you could provide us an estimate of when the backend will finally be fully automated, would be great. Second one is HHS recently announced that 800,000 Americans enrolled in coverage through healthcare.gov received inaccurate tax forms under the ACA. We would like a detailed assessment on when the Department expects these taxpayers will have accurate information in hand so that they can file their taxes. And third, many Americans were automatically re-enrolled in exchange plans, raising concerns that individuals and families may be getting unexpected premium bills, or inaccurate exchange subsidies in 2015. We would ask that you submit specific data on the number of Americans who have been automatically re-enrolled in those exchange plans. So that would be helpful.

Now I will return to 21st Century Cures, and again, appreciate your personal assistance with this. And I, for the record, want to certainly thank Dr. Collins, Commissioner Hamburg, Dr. Woodcock, and Dr. Shuren, countless others at your department for the help on 21st Century Cures. Because of that participation, and participation of folks from across the country, we have been able to learn more about the status of innovation in this country, and

we hear about ways to accelerate the discovery, development, delivery of cures and treatments for patients.

As we heard at our first roundtable, there are over 10,000 diseases, and we have only cures and treatments for about 500, so we have a great deal of work ahead to do. We released a discussion document last month, and have been working with Congresswoman DeGette, Ranking Member Pallone, Mr. Green, other members of our Committee, and on both sides of the aisle to improve that document. One area that includes a placeholder is precision medicine, something the President talked about in the State of the Union Address, and subsequently a White House event a couple weeks ago. We did put that placeholder into the draft, and we look forward to continuing to work with you, and the White House, the Administration, on that important issue. Could you give us a background on the Administration's precision medicine policy, and what we should look forward to?

Secretary BURWELL. Thank you, and thank you for the partnership, as we work through these issues together, and it is exciting to have the energy around these issues, including the precision medicine, which is, I think, a subset of the broader issues you are looking at. Our precision medicine initiative is $215 million, with regard to—as we think about it from a budget perspective.

But I think thinking about it from the pieces and what it is doing, one part of the initiative is creating a very large database of a million people through NIH, but we will access that through other channels, so that we are drawing from existing databases to get the information we need, because, as we are talking about what this is, precision medicine, or personalized medicine, is getting the information so that we can do treatments that are to the individual.

I was at NIH recently, had the opportunity to both see the tumors and meet the cancer patient of a kidney cancer patient, where he had a group of tumors removed. They came back, but then, using precision medicine, which meant looking specifically at the genetic makeup of his tumors—be treated in a different way. I met him. That happened months ago, and now he—the patient was there, discussing it with me, and is a very different place. So, one, that large database. Two, specifically focusing in the area of cancer, because we already are seeing some progress there, and we believe that place is right for it.

The other thing we need to do is FDA. Make sure that, as we think about precision medicine, we regulate, and think about how to improve these things in ways of a different type of medicine. And then finally, we need the health records, the Office of National Coordinator for Health—Electronic Health Records to be a part of making sure this will do with payments, and how clinicians will use. Those are the elements.

Mr. UPTON. Well, I just want to say, that is very helpful, and we are excited as well. And though I have been out to the NIH a number of times in the past number of years, I want to remind members here that we have got a committee trip—I have invited, I think, all the members on this subcommittee to go out to the NIH next Monday morning. Dr. Collins has been very interested in having us out to kick the tires, like you saw yourself.

And I know that, because we have votes tomorrow, Friday, and again on Monday, and perhaps over the weekend, there may be more of us here over the weekend than originally thought. So I want to remind members that they are invited to join with us and not miss votes come Monday on a trip there, and I yield back. Thank you very much.

Mr. PITTS. Chair thanks the gentlemen. Now recognize the Ranking Member of the full Committee, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Hello, Secretary Burwell. I am sure you can sense that I am very proud of the Affordable Care Act, and concerned about Republican efforts to repeal it, or now take it to court, in the case of King vs. Burwell.

Are you aware of any Republican bill that would reduce the number of uninsured in this country by 11 million people—I said 11, it is actually 19 million people, the way that the Affordable Care Act does? I mean, obviously I am saying this because I don't see them coming up with any alternative.

Secretary BURWELL. You know, we haven't, and I think it is important to reflect, historically, when one looks at the history, and actually I have gone back to Teddy Roosevelt, and the quotations from Teddy Roosevelt forward, through both Republican and Democratic administrations, we see—whether it was President Bush, President Nixon, President—Republican and Democrat, President Clinton, the conversation about how we make this next step forward, with regard to reducing uninsured, is something that we struggled with as a Nation.

And this is the first time, and someone reflected on the anniversary of Medicare, and that 50 year anniversary, this is the first time that we have seen that. And so the plan that we have in place, the implementation of the Affordable Care Act, has done that. But we have not seen any alternatives.

Mr. PALLONE. All right. Let me ask you about CHIP. All the Democrats on the Committee recently introduced a bill to extend the CHIP program, and I want to emphasize again that we have to act on this legislation immediately, when we consider SGR, which expires at the end of March. While funding may not expire until the end of September for CHIP, in fact, 20 states will finish their legislative sessions by the end of April, and more than half by June 1, so it is clear that Congress needs to act swiftly to ensure states can budget appropriately for CHIP, and avoid any disruption in children's coverage. So, given the bipartisan history of this program, I see no reason why Congress can't act very soon.

Can you comment on the impact on states if the CHIP funding isn't extended soon?

Secretary BURWELL. I would comment on that from two different perspectives, one as former director of OMB, and the issues of predictability of funding, and the issues of management, and ability to manage. And so, for the states to be able to do that, this is something that is important. When we have had predictability in our own budget system, we have seen the benefits of that economically throughout the past years—2 years.

And the other thing I would say is, having just spent a lot of time with the governors this weekend when they were in town, this

is a very important issue to them. We have seen that letter that 40 governors have signed with regard to knowing that they have that predictability of a program that is providing great benefits to the children in their states.

Mr. PALLONE. Now, the Senate and House Republicans have released a CHIP proposal this week, however, this proposal would institute a 12-month waiting period, needlessly forces low income children off of Medicaid and onto CHIP, and reduces or completely discontinues coverage for children above 250 percent of the Federal poverty level, despite the choice of 28 states around our Nation to cover those kids. Can you discuss the impact of policies like this on some of our most vulnerable children?

Secretary BURWELL. So we think that the CHIP program is a program—bipartisan program, and a program that is working a delivering results, in terms of that quality health care for those children, and has worked. We believe, that is in our budget, a 4-year extension of the program, is a very important thing, and that we need to do that in a timely fashion to both make sure those children are covered, and receive the care that they need, but also, in addition, to have that predictability for states, especially those states that are in their legislative process right now.

Mr. PALLONE. And I know you mentioned the 4-year extension. The budget includes a 4-year extension of the CHIP program. Can you talk about why that full extension of 4 years is so critical for the kids that depend on this health coverage? And maybe also mention, as part of the extension, the budget includes a permanent extension of express lane eligibility. If you would talk about the success of express lane eligibility as an option for states?

Secretary BURWELL. So the express lane eligibility, and those issues, we—folks ask us to try and figure out ways to simplify, to make things easier, and that is making things easier in two ways. When we hear from folks, it is about both the customer, in terms of when they came in, as well as the states. And we believe this is a program that has been successful in getting to that simplicity, and the simplicity often can work to create either A, better quality, or B, lower costs, and so we think that is important—4 years, we believe that is a good amount of time, and the right amount of time for us to do this extension. There will be interaction with the Affordable Care Act, we know that, and we believe that the 4-year period is the right period for us to understand and look at that.

Mr. PALLONE. Thank you. Mr. Chairman, I would like to submit for the record two CHIP articles. The first is an op-ed published in the New York Times this month by former Secretary Hilary Clinton, and former Senator Bill Frist, discussing the long term bipartisan history of the program, and the importance of a 4-year extension. And the second article was published in the New York Times last month, shows how health coverage for children pays for itself, and all the research showing that when children have health coverage, future earnings are boosted. If I could——

Mr. PITTS. Without objection——

Mr. PALLONE. Thank you, Mr.——

Mr. PITTS [continuing]. Ordered.

Mr. PALLONE [continuing]. Chairman.

Mr. PITTS. The gentleman yields back. Chair now recognizes the Chair Emeritus of the full Committee, Mr. Barton, 5 minutes for questions.

Mr. BARTON. Thank you, Mr. Chairman. Thank you, Secretary, for being here. As I have talked to you before, there are lots of problems that we have to deal with, you in your position, and the Committee in our position. But there are some opportunities for bipartisanship, and one of them is a piece of legislation that we call the Ace Kids Act. The original co-sponsors are Ms. Castor of Florida, I think Ms. Eshoo of California, Mr. Green of Texas, myself, on the Republican side, along with several other members of this committee on the majority side.

You said in your opening statement that Medicaid is going to be about $345 billion this year, an increase, I believe, of over 16 billion. Well, there is one piece of legislation we could pass on a bipartisan basis that would actually save money in Medicaid, and that is the Ace Kids Act. It creates a home for families that have medically complex children, based on an anchor hospital concept with the major children's hospitals in America. I think there are about 60 of them. So if a parent has a child that is medically complex, and qualifies for the program, that child gets access to the network on kind of a one stop shop. All the specialties, all the various procedures are provided, and Medicaid is billed on time. We think there are about 12 million children that would qualify for the program, and we believe that it will save billions of dollars over a 10 year period.

It has been introduced in the Senate, the identical bill, with three Republican co-sponsors, three Democrat co-sponsors. So here is a rare piece of legislation that both sides of the aisle support. The Republican leadership supports it. Chairman Upton supports it. Chairman Pitts supports it. Does your department have a position on the bill, and if so, could you explain to the Committee what that position is?

Secretary BURWELL. So with regard to the specific legislation, I don't think we, as an administration, have issued—but what I would say is all of the concepts, we agree, and we welcome the opportunity. The idea that we can improve both quality and cost for these children, who are very complex, and who are moving state to state, and the current system doesn't afford us the opportunity, both with regard to making sure we don't have duplicative payments, we obviously do not want that, fiscal responsibility, and we want that ease that the parent can have the child at the right place with the right care, even if it is across state lines.

So I would just say we look forward to working with you, welcome the opportunity, if there are questions and ways that we can provide technical assistance and other things as part of this, we welcome that opportunity, because we agree with the fundamental of what we are trying to do here, and believe this is something that could improve both cost and quality.

Mr. BARTON. Well, I would encourage you and your department to take a look at the bill. It is not illegal or immoral for the Administration to issue a letter of support, and this is one that I think, with Chairman Upton and Chairman Pitts, and the Ranking Member in the full Committee and Subcommittee, and leadership on

both sides of the aisle of the House said this bill could go. It could be a part of Chairman Upton's 21st Century effort, or it could be a stand-alone bill.

I also, in the brief time I have, want to concur with what Ranking Member Green said about community health centers. I hope we can work together in a bipartisan fashion to find an answer to keep those funded. I know there is a funding issue this year that we need to address, and reauthorize the program. I have a number of those health centers in my Congressional district, and they are very helpful, providing indigent care.

And, finally, I wasn't going to ask this question, but I am a little bit puzzled. When Chairman Pitts asked you the question about this report that deals with planning in case——

Secretary BURWELL. Yes.

Mr. BARTON [continuing]. The health exchanges at the state level under the Affordable Care Act are found to not be legal the way they are currently funded, if there was a plan, and if you had seen the plan, I take you at your word that you haven't seen the plan, but don't you think it is prudent that there should be a plan? I hope I don't have a primary opponent, I hope I don't have a general election opponent, but I have a plan in case I do. I know you hope that the Court upholds your position, but shouldn't the Administration and your agency have a plan in case it fails?

Secretary BURWELL. Congressman, what we state in the letter, and what we believe is, if the Court decides, which we don't believe they will, but if the Court decides on behalf of the Plaintiffs, if the Supreme Court of the United States says that the subsidies are not available to the people of Texas, we don't have an administrative action that we could take. So the question of having a plan, we don't have an administrative action that we believe can undo the damage.

And that is why, when I was answering the Chairman, I think it is important to understand what the damage is, because then it comes to the question of—we don't believe we have any administrative——

Mr. BARTON. So, my time has expired, but if the Court strikes it down, the Administration is just going to hold up your hands and say, we surrender?

Secretary BURWELL. We believe the law as it stands is how it should be implemented.

Mr. BARTON. I understand.

Secretary BURWELL. And with regard to—when the Supreme Court speaks, if the Supreme Court speaks to this issue, we do not believe that there is an administrative authority that we have in our——

Mr. BARTON. All right.

Secretary BURWELL [continuing]. To undo it. And so that is——

Mr. BARTON. That is——

Secretary BURWELL [continuing]. Something we don't believe we have and——

Mr. BARTON. That is puzzling but I accept that. Thank you, Mr. Chairman, for your courtesy, and the minority, for letting me have extra time.

Mr. PITTS. Chair thanks the gentleman, and now recognize the gentleman from New York, Mr. Engel, 5 minutes for questions.

Mr. ENGEL. Thank you very much, Mr. Chairman, and welcome, Secretary Burwell. Let me piggyback on a backup plan. I was part of this committee. I participated in months and months of deliberations for the Affordable Health care Act. We had weeks of markups, this committee did, and not once was there mention of subsidies not being available to individuals in states that did not set up their own exchanges. I have heard a lot of complaints on the other side of the aisle about the law, but never was this issue discussed until they lost at the Supreme Court in 2012.

Some of my friends signed on to amicus briefs, and wasting credible time forcing votes on the full repeal of the law, yet they are upset that the Administration doesn't have a backup plan, should the Supreme Court ruling threaten the availability of subsidies for 8.6 million Americans. And I think it is somewhat ironic that my Republican friends are demanding that this Administration fix problems that they themselves created, and have shown zero interest in fixing. Should Republicans get what they want, and the Supreme Court rules in favor of King, I would urge my colleagues, if that should happen, to pass legislation to ensure that Americans have continued access to affordable coverage through the Federally facilitated exchange, just as Democrats intended.

Next month the Affordable Care Act will have been the law of the land for 5 years. It is not a perfect law, and there are issues that need to be changed with it, but I would like to see those issues addressed. And let us both of us, in a bipartisan way, turn our focus on improving the law, and enabling more quality coverage options for our constituents, instead of trying to kill it, repeal it, take it to court, and things like that. So I just wanted to say that I am sure that you agree with what I just said.

Secretary BURWELL. Yes. We look forward to moving forward, and we do want to make improvements as we can.

Mr. ENGEL. Thank you. And I want to use my home State of New York as a great example of what is possible when the Federal Government has a willing and enthusiastic partner in the Affordable Health care implementation. As a result of our successful exchange and Medicaid expansion, more than 2.1 million New Yorkers have quality health care coverage. Our state's uninsured rate has dropped to only 10 percent. And there is clear evidence we are reaching the right people too, since 88 percent of people who obtained coverage through the exchange reported being uninsured at the time they enrolled, so it is really working in New York. And the health insurance options available through New York State of Health are on average 50 percent cheaper than the comparable coverage available before the exchange was established.

So I want you to know, I am sure you know it, that the ACA is working, and working well in New York, and that is why I really think it is terrible that I have been forced to take more than 50 votes to repeal some or all of this law. We should fix what is wrong. But in my state, it has really been a tremendous success.

Secretary BURWELL. And, fortunately, I have had the opportunity to travel the country and see the individuals, those are the numbers, and the individuals, and whether it is Laura in Florida, 26

years old, married to someone who is a truck driver, who does not have coverage. She is training to be an X-ray tech, they have two children. They did not have insurance. She now has insurance with a premium of $41 a month. Or a woman who had MS in the State of Texas, and for 17 years she had not had health insurance. And so how people go about—she treated her MS through the emergency room, and she has four children, and she works. And so, when it would get bad enough, that is what she would do. And so the stories of what it means to people, in terms of their financial and health security, I think are—the numbers are important, but it is those stories which really make this real.

Mr. ENGEL. And Secretary Burwell, I understand that we have seen robust exchange enrollment nationwide, even in states where Republican governors refuse to set up a state exchange, or expand their Medicaid programs. Isn't this true?

Secretary BURWELL. So the numbers—and I spoke to this yesterday, when we would been able to look at the numbers, 53 percent of the enrollees in the marketplace this year, in the Federal marketplace, are new enrollments. And so I think that is indicating that—the demand for the product, and the need for the product.

Mr. ENGEL. Thank you. I want to second Mr. Pallone's positive discussions about CHIP. I have always been a strong supporter, and, as of July 2014, an estimated 476,000 children were enrolled in this affordable coverage option for their care in New York, and so I think that that is really, really important. I was pleased, therefore, to see with the budget proposal for fiscal year 2016 included funding for CHIP for the next 4 years, through fiscal year 2019. So can you elaborate on why you believe increasing tobacco taxes is a viable means for funding this program while we sort out the transition issues associated with the Affordable Care Act?

Secretary BURWELL. We believe one of the things of trying to be fiscally responsible, and indicating how we are paying for things, we believe that this is a legitimate way to pay for things, especially in the context of we are providing health care, and something that will hopefully create a deterrent, and help health care, in terms of the issue of a tobacco tax. As one analyzes across the Department, and whether it is at CMS or CDC, the impact that tobacco has on health in our Nation, and the cost of health care in our Nation, is one that we think is a fair place to go to pay for this care for the children.

Mr. ENGEL. I agree with you. And, finally, I want to talk about graduate medical education, because I was concerned that the Administration's proposal to cut enduring GME funding—one in six physicians in America obtains training in my home State of New York, and we have some of the finest academic medical centers in the country. So you require significant funding and time to develop the infrastructure and expertise necessary to ensure quality care is available. So how do we ensure stability for these academic medical centers, and the patients they serve, if we put GME funding at risk?

Secretary BURWELL. We believe and hope that our proposal does not do that, and meets the objectives of making sure we are training appropriate positions for both primary care and specialties, where we don't have as many as we should, at the same time, mak-

ing sure we target it. There is $100 million for pediatric, and then a wider pool for competition. It is an issue that we want to meet the same objectives at the same time we do it in a fiscally responsible way.

Mr. ENGEL. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. Chair thanks the gentleman. Now recognize the Vice Chairman of the Subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Madam Secretary for coming, and I really look forward to working on 21st Century Cures, and all the things that we could work on over the next years as Vice Chair.

But first I would like to direct your attention to the cost share reduction program contained in the ACA, specifically Sections 1402 and 1412. Does any part of this budget request, or does any part of this budget that we are talking about today request any new authority, including any transfer authority to pay insurers under the cost share reduction program?

Secretary BURWELL. With regard to the program, which, as a program, as you know, is about making sure that the costs of health care to this individuals that are coming into the marketplace is something that they afford, that is what it is about, and we believe that we do have the authorities to do the cost sharing.

Mr. GUTHRIE. Is there any new authority requested in this budget?

Secretary BURWELL. No new language.

Mr. GUTHRIE. There is no new language? And so we do know it is up and running. I think we spent $3 billion already on the cost share reduction program, that are then paid to insurers with taxpayer funds. The budget that is being submitted estimates 11.2 billion over 2015–2016, and CBO says 175 billion over the next 10 years is what they have estimated. And could you cite where the appropriations authority is? You said you do believe you have the—can you cite where that is?

Secretary BURWELL. We do believe we do, and I am sure you know that right now this is an issue that is under litigation, and a court case that has been brought. And so, with regard to that, that is an issue that I will let our colleagues at the Justice Department speak to, because of the place it is in litigation.

Mr. GUTHRIE. I understand that, but we are doing oversight here. I am not an attorney, so—when you were at OMB in 2014, there actually was a request in the 2014 budget for direct appropriation, and that didn't happen, for whatever reason, but we are spending money. So whether we spend a penny or 100—this is $175 billion over 10 year program. We feel like we—this is an oversight hearing, and so we feel like it is our responsibility to make sure to our taxpayers that we have good answers on where this is coming from. So we are just asking for where the appropriation comes from authority.

Secretary BURWELL. I understand and I appreciate the question, and I am sorry that it is in litigation. I wish we weren't in a place where we are in litigation, but once something has entered into that place, it does create a difficult circumstance. I respect the issue of oversight, but because the litigation has been brought by the House——

Mr. GUTHRIE. Yes.

Secretary BURWELL [continuing]. On this issue, we are in a place where I think that is the appropriate place for this conversation.

Mr. GUTHRIE. We are really—I am just not aware of any pending litigation exception at oversight hearing questions, and—is there, like, a legal case, or authority, or did the Justice Department say you don't have to——

Secretary BURWELL. With regard to issues that are being litigated, generally those are matters that we refer, and let the Justice Department continue on.

Mr. GUTHRIE. And—that we have never been able to get an answer from the Administration for where the language—nobody has even been able to point to us where that appropriation language comes from. And it was—and you previously had requested appropriation.

Let me ask you another question. You had recently said—you received—I think 18 employer groups sent you a letter, urging that small groups be maintained at 50 employees. And they were citing an actuarial analysis that showed when they go to 50—to 51, actuarial analysis said that it would—estimated that ⅔ of the members—so they would receive an increase, and—of 18 percent. And I just don't believe that these small employers, 50 to 100 employees, can accept an 18 percent increase in their premiums. Also, the promise that if you like the plan, you can keep it, because if the 50 to 100 have to go into the new plan, they will have to meet the requirements of the health care law that—essential benefits, and the other things that have caused other people to lose the plans that they liked, that they could keep.

And due to this impact, would you support allowing states to keep their market at 50 or below, not go to the 51 to 100?

Secretary BURWELL. This is an issue that we are looking at and examining because we have a number of comments on it. And what I would say is I would welcome the opportunity to see the piece of work that you are talking about and referring to so that we can see and understand that. I think what we want to do is understand the facts around this type of thing, so I would welcome the opportunity to see the study and piece of work that you are articulating.

Mr. GUTHRIE. OK. My understanding, it has been submitted, a letter from these 18 employers, but we will make sure that that is——

Secretary BURWELL. OK.

Mr. GUTHRIE. Well, thank you, Mr. Chairman. I yield back.

Mr. PITTS. Chair thanks the gentleman. Now recognize the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman, and thank you, Madam Secretary, for being here today. I wanted to ask you if you are aware of any Republican legislative proposal that would keep insurance companies from denying coverage from people with preexisting conditions, like cancer, or dropping someone from coverage because they got in an accident, or got sick?

Secretary BURWELL. I am not aware of a piece——

Ms. SCHAKOWSKY. That is right.

Secretary BURWELL [continuing]. Of legislation that would take care of that issue.

Ms. SCHAKOWSKY. And are you aware of any Republican legislative proposal that would provide access to preventive services, like cancer screenings, yearly wellness exams, and do that at no additional out of pocket cost to consumers?

Secretary BURWELL. I am not aware of a piece of legislation that would do that in the way that the ACA does.

Ms. SCHAKOWSKY. Thank you. I wanted to talk a little bit about something that is a growing concern, and that is Alzheimer's disease, and the cost that it is in personal lives, and also in funding. So scores of public agencies, including many HHS agencies, as well as numerous private and non-profit organizations, are trying to address this challenge of preventing Alzheimer's, serving those who have dementia today, finding a cure. Shouldn't the Federal Government be coordinating a plan on Alzheimer's?

Secretary BURWELL. In terms of the issue of coordination, there is a body, an advisory group, that includes both people from the Federal Government, as well as external folks, to be a part of putting together our thoughts and strategies, and it has informed the way that we are doing investments. There are members of the Federal Government across the government, as well as external bodies that are a part of that.

With regard to the work at the Department, the work cuts across a number of different areas. NIH and research is generally what comes to mind for most people, but where the biggest dollars are spent is actually in CMS, and making sure that we are thinking through the issues in that space, because that is where the dollars—the other thing is the Administration for Community Living is where we work on and think about things like those that are caregivers, and those that are going through that process of dementia, and how they deal with it. So at the Department we work through all of those. There is this overall advisory group that we have externally, and includes internal members.

Ms. SCHAKOWSKY. So the population is aging rapidly, obviously, and Alzheimer's is taking a much bigger toll than ever on families, on health care systems, on people who have the disease, and the number of people living with dementia will continue to grow as baby boomers age. So you had mentioned the research that is going on, so what is HHS, NIH doing to find a cure?

Secretary BURWELL. So in this budget you see a 24 percent increase to funding for Alzheimer's, which is much greater than the percentage increase even within the other NIH, so focusing deeply on doing that. It is also part of the BRAIN Initiative, as we think through their specific issues. But we are also making progress on something called TAL, which is a protein that is indicative of Alzheimer's. That is one of the pieces of research that is going on, and if we can make progress there—the other piece of research is seeing if there are ways that we can slow the progression by understanding how the neural channels move, and what is happening in the disease. Those are pieces of research that we are starting, we believe that, with the funding we are asking for, that we can move that research—we can broaden it, and we can make it faster.

Ms. SCHAKOWSKY. So dementia is a major focus of work in the United Kingdom and other developed countries. Are we keeping up with the rest of the world in research activities and investments?

Secretary BURWELL. You know, we believe that we are, with regard to that, and I have been in touch with my colleagues and the secretary—or the minister in the U.K., and continue to have those conversations. So we make sure that we are leaning, and staying connected to our colleagues, especially that particular example, where I have been in touch with Mr. Hunt, and will continue to do that so that we make sure that we are learning everything we can from our colleagues. And in places where we can work together, see if we can leverage the efforts that are going on in each of our countries. And that is both across the research, the regulation, as well as the more social issues.

Ms. SCHAKOWSKY. And who is on the Alzheimer's Advisory Committee? I am asking that because shouldn't there be a person with Alzheimer's as part of the group?

Secretary BURWELL. I want to get back to you directly, but it is my understanding that there is a person, that there is a slot, and that either there is or will be a person that does have that is part of the committee. I will want to get back to you on that, though, specifically.

Ms. SCHAKOWSKY. Well, I want to thank you for the focus, and, as the coach here of the Seniors Task Force of the Democratic Caucus, I really want to work with you on that, because this is a problem affecting so many families and individuals. I appreciate it, and yield back.

Secretary BURWELL. Thank you.

Mr. PITTS. Chair thanks the gentlelady. Now recognize the gentleman from Kentucky, Mr. Whitfield, 5 minutes for questions.

Mr. WHITFIELD. Thank you. Well, Secretary Burwell, I also want to thank you for being with us today, and I want to just follow up on my colleague Brett Guthrie's question. We are concerned about this cost sharing program because it is $170-some billion dollars over a number of years, and we understand that that is one of the issues involved in the lawsuit. But all we are asking you is, since you all are dispersing the money, what is your opinion as to where the appropriation is designated that you are working from?

Secretary BURWELL. This is an issue—as I said, I understand the question. We believe we have the authorities. With regard to the specifics of that, because we are in litigation——

Mr. WHITFIELD. But you can't tell us where the money is coming from?

Secretary BURWELL. With regard to having that conversation, that is what the——

Mr. WHITFIELD. Were you instructed by DOJ not to answer that question?

Secretary BURWELL. With regard to that specific issue, that is at the root of the litigation.

Mr. WHITFIELD. Were you instructed by DOJ not to answer the question?

Secretary BURWELL. With regard to—when there are issues of litigation like this, our standard——

Mr. WHITFIELD. Well, yesterday we had Gina McCarthy here, and we were talking about 111(d), which is before the Supreme Court right now, and she gave us her theory of why she thought she was right. We are not saying that we are right or you are right,

we are simply asking what is your theory? Where does the money come from, in your view?

Secretary BURWELL. That is something, as I said—why don't I work to get back to you on where we feel comfortable——

Mr. WHITFIELD. OK.

Secretary BURWELL [continuing]. With regard to where the litigation is, and I would like to come back on that.

Mr. WHITFIELD. Well, I must say, I have been impressed with your facility to use numbers. You are really tuned into the budget, responding to Mr. Pitts, responding to Mr. Green about the community health centers. I was at a Rotary Club meeting recently——

Secretary BURWELL. Yes.

Mr. WHITFIELD [continuing]. And I was asked the question—they said, Congressman, can you tell us what dollar amount has been incurred by the Federal Government as a result of state expansion of Medicaid programs pursuant to the Affordable Care Act? Because we picked up a larger percentage of the normal cost.

Secretary BURWELL. Yes.

Mr. WHITFIELD. And I would ask you that question. I didn't know the answer, but could you tell me what is the total dollar amount incurred by the Federal Government by the expansion of the state Medicaid programs as a result of the Affordable Care Act?

Secretary BURWELL. In terms of the Federal dollars versus the state dollars?

Mr. WHITFIELD. Yes, just the additional dollar——

Secretary BURWELL. Yes, I——

Mr. WHITFIELD [continuing]. Amount incurred by us.

Secretary BURWELL. Let me go back and look, because the question of being able to disaggregate whether a person came in because of expansion, or were under the old rules, I think—I would want to make sure that we could——

Mr. WHITFIELD. But you don't have a dollar amount for that?

Secretary BURWELL. I don't know. I will check with the Department if we do. The one thing that I think we——

Mr. WHITFIELD. You would think that you all would definitely know that—we can all talk about the advantages and disadvantages of this program, but there is a big additional cost to the Federal Government, and I am asking what is that total dollar amount incurred?

Secretary BURWELL. I think the question that I am not sure is how one breaks out the actual number from expansion. Because when people come through——

Mr. WHITFIELD. Well, let me ask you this question——

Secretary BURWELL [continuing]. That is where——

Mr. WHITFIELD [continuing]. At what year does—the states were encouraged to expand Medicaid, which is fine, because the Federal Government is picking up more of that dollar amount.

Secretary BURWELL. Yes.

Mr. WHITFIELD. But at some point in the future the Federal Government is not going to be picking up those additional costs. What year is that?

Secretary BURWELL. What year that is is—the Federal Government never goes below a 90 percent of the payment of the additional, and that is——

Mr. WHITFIELD. Until when?

Secretary BURWELL [continuing]. 2020 is——

Mr. WHITFIELD. 2020?

Secretary BURWELL. And so 2016 is the year through which there is 100 percent.

Mr. WHITFIELD. OK.

Secretary BURWELL. And in your own state——

Mr. WHITFIELD. Well, do you have any projected cost over that period of time for the Federal——

Secretary BURWELL. We do have those incorporated in our budget. But one of the things, in terms of these cost issues, that I think are important in the State of Kentucky——

Mr. WHITFIELD. OK. Well, that is OK. Listen, you can't answer the question, but I appreciate it anyway. Let me ask you this. I noticed that you all made $2.5 billion in loans in the co-ops, and Kentucky has a good co-op program as well. We sent a letter last year, and we were concerned about the solvency of some of these co-ops. And the Federal Government, as I said, has loaned $2.5 billion. We now see that in Iowa and Nebraska, those co-ops are in bankruptcy. Have you all done any analysis to project—are there other states that there is a chance that these co-ops will go into bankruptcy? Are you looking at that?

Secretary BURWELL. We are looking at the co-ops. The one thing I think is very important to note is the cuts, the deep cuts in the funding for co-ops. When the program was originally designed, and the passage of the Affordable Care Act occurred, the amount of money for the co-ops to do the loans, and the loans that states like Iowa felt would have made a difference, at the end, because those monies were cut, they were cut as part of sequestration. They were cut in '12, they were cut in '11, they were cut in '13.

Mr. WHITFIELD. So are you saying the bankruptcy occurred because of sequestration?

Secretary BURWELL. What I am saying is that, had we had more funding in order to provide the additional loans to the co-ops, it could have made a difference. With regard to the fundamental of your question, which was are we looking at the co-ops? And there are two things that we want to do, understand whether they are stable, and then the second is where we can provide technical assistance.

Mr. WHITFIELD. Well, those questions that you couldn't answer, or were not familiar with, I do hope that you will get back with us with those answers soon.

Secretary BURWELL. Be happy——

Mr. WHITFIELD. Within 7 days, if possible. Thank you.

Secretary BURWELL. I will——

Mr. WHITFIELD. Thank you.

Secretary BURWELL [continuing]. Want to make sure that—we will get back as quickly as——

Mr. WHITFIELD. Because I have got to be back at that Rotary Club next week.

Secretary BURWELL. As a neighboring state, I appreciate that.

Mr. PITTS. Gentleman yields back. Chair recognizes gentlelady from Florida, Ms. Castor, 5 minutes.

Ms. CASTOR. Thank you, Mr. Chairman. Madam Secretary, thank you again on behalf of the 1.6 million Floridians that were able to buy affordable health insurance in our exchange. I will give you due credit, and everyone at HHS, but I think the real credit goes to our terrific navigators that were on the ground, hospitals across the State of Florida, community health centers, and family members that probably put in a good word for their sons and daughters, or aunts and uncles, to sign up. You probably want to give them a pat on the back yourself this morning. I encourage you to do that.

Secretary BURWELL. I do. I want to express appreciation. I have seen the local stakeholders, and met with them across this country, and it was the communities coming together, it was individuals, it was people in the community health centers, as was mentioned, it was the businesspeople, it was everyone. When I would visit, the hospitals would be there, everyone would be around the table working on this issue together, and it was that kind of work—and then the individuals that I visited——

Ms. CASTOR. OK.

Secretary BURWELL [continuing]. On Second Sunday in Texas—actually was given the opportunity to speak at one of the churches. And it was all of that coming together to give this information to people so that they could make choices, and have that financial and health security.

Ms. CASTOR. So, in Florida, we have a very competitive marketplace as well. Consumers could choose from 14 different issuers in the marketplace this year. That was up from last year, where we had 11. And Florida consumers could choose from an average of 42 health plans in their county for 2015 coverage.

So with 1.6 million now enrolled, it really demonstrates the high stakes involved with the Supreme Court case that the Court will hear next week. I cannot imagine that the Court would rule to take that away from over a million and a half Floridians, and then millions more all across the country. And just like Representative Engel said, I was here during the hearings in advance of the Affordable Care Act, the adoption, during the markup, during the amendment process, during negotiations with the United States Senate. Never in those discussions was there any dichotomy between a state exchange, and a Federal exchange, and the availability of tax credits. Have you seen any evidence to the contrary, in your review of the record, and the case that is before the Supreme Court?

Secretary BURWELL. With regard—I would let the Justice Department, who has reviewed everything—but the thing that I agree with is we we just don't believe that that is what the law says, or what was intended by the law either.

Ms. CASTOR. Yes, and I can say straightforwardly, as a member of this committee, what the legislative intent was, and it was for those tax credits to be available to every American, no matter if they are in the state marketplace or a Federal marketplace. But I would say if the Court rules otherwise, they are going to create chaos, and they are going to strike right at the heart of the economic security of so many of my neighbors in Florida, and many Americans. So I know that they will study the legislative intent,

and I hope they rule the right way, and we don't have the address that chaotic situation.

But I think, with the Affordable Care Act, the real untold story is what has happened to people who have insurance, because I can cheer on the million and a half Floridians that now have it, but most of my neighbors already had insurance, private insurance or Medicare, and I noticed some more good news that was announced this week for my neighbors that rely on Medicare. Just in Florida alone, Floridians have saved almost a billion dollars since 2010 because of the ACA's donut hole discount. Almost 350,000 beneficiaries saw savings in 2014, to the tune of about $300 million last year. The average discount per beneficiary was $884.

Then, for private insurance—how come we haven't been able to get the word out on how much better an insurance policy is that a consumer can't be kicked off if they get sick? In Florida alone, over 200,000 young adults can stay on their parents' plan. Floridians have received millions of dollars in rebates because the law says, you have new rights and protections, and insurance companies cannot spend that money on profits. It has to go to—it can't spend the profits on salaries and excessive profits. It has to go to health care. What else can the administration do to tell this good news story?

Secretary BURWELL. I think we can do a better job of making sure people do know. And another area is the issue of preventative care, and the importance of the fact that your childhood visits and those things are no longer—require co-pays or cost sharing, in terms of when you go in for that, or measles, an important thing, I think, right now, and a timely thing. And so I think we need to do a better job of making sure people know about those improvements to quality.

Ms. CASTOR. Thank you. I yield back.

Mr. PITTS. Chair thanks the gentlelady. Now recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you. Secretary Burwell, thank you. I talked to your staff prior. I appreciate your outreach, trying to call. It was a crazy day, and I talked to them before you——

Secretary BURWELL. Thank you.

Mr. SHIMKUS [continuing]. Came to the table. And I do have great respect for that. But I also want to make sure that, you know, this happy clap talk about how great health care is, and the Affordable Care Act, is moderated by real concerns out there.

Remember, the bill that passed, signed into law, we had nothing to do with on the House side. It was a Senate health bill that came over to us that we passed, all right? So that is the health care law that we have today, and the language of the law is pretty clear, and I am concerned also that the Supreme Court will rule that the Federal exchanges and states are not authorized to receive subsidies, and we need to be prepared for that here, and I would hope the Administration would be too.

I promised two ladies from my Congressional district that I would mention their names. Angie Esker from Teutopolis, who is pro-life, a strong family, and she cannot buy a policy that does not have abortion coverage. And for millions of Americans, this is a

really important issue, and she—this is an emotional—just like on the other side, you know how this debate is.

Secretary BURWELL. Yes.

Mr. SHIMKUS. And I think part of the agreement from some of my pro-life Democrats was to ensure that that option would be available——

Secretary BURWELL. Yes.

Mr. SHIMKUS [continuing]. And it is just not for her. The other one is Debbie McKinney-Huff from a town called Highland. She is a Democrat. Her premiums went up astronomically last year. This year they have gone up another $2,000, with a $10,000 deductible, and she can't afford it. So for all the happy dances, there are challenges out there that—we don't do our constituents service if we don't understand that there are problems that have to be resolved. There are some budget requests that I want to talk about, so I am going to move forward, but I just put that in the record.

I am a big supporter of Medicare Advantage. I was here when we passed it. Seniors didn't have any prescription drug coverage. It has been very successful, it is very popular. The budget request makes a reduction again in that, where the enrollment is going up, favorable are high, and 670,000 people weren't able to access Medicaid Advantage. And if you are from rural parts of this country, that option is very limited, or it doesn't exist. So I would ask that we look at that, so that seniors who want to have this option can choose that. And our concern is your budget hurts the ability for that to happen.

Secretary BURWELL. So with regard to the first issue, in terms of your two constituents, want to make sure we understand that. On the issue of the question of abortion, and that——

Mr. SHIMKUS. Well, let us just answer this question, because I have got to keep more on budget——

Secretary BURWELL [continuing]. Medicare Advantage issue.

Mr. SHIMKUS. Thank you.

Secretary BURWELL. With regard to that, we want to make sure—the program during the period of changes that we have had, we have seen a large increase in the number of people in Medicare Advantage plans. I want to understand your 670, because 99 percent of beneficiaries have access to MA plans, and there may be something, and so I would like to understand that 670 better.

The third thing is that we know that those number of plans quality that have gone from four stars to the higher ratings, we have offered 67 percent in the two highest rating categories, 17 percent to 67 percent, so we are improving quality. More people are coming in the system, and there is premium control, so I want to understand the 670. We want to make sure, and are listening. We alter our plans as we hear concerns. That is why I want to understand that 670, because we believe that we can continue making these changes. It comes back to some of the points the Chairman raised with regard to deficits, and making sure that——

Mr. SHIMKUS. OK.

Secretary BURWELL [continuing]. We are being responsible. MedPAC and the GAO have recommended that there is upcoding, and we need to work on it.

Mr. SHIMKUS. OK. Thank you. Are you aware of any efforts by FDA to accelerate the next round of user fee negotiations? And our concern is, if they are, and they are not doing due diligence about the fees and the return on investment, we would hope that they would not accelerate it until due diligence is done.

And the last thing I wanted to address was the Biologics Price Competition and Innovation Act. Stakeholders have to be involved in that. That is really part of the 21st Century Cures debate, not just having bureaucrats or panels, but bringing patients, bringing physicians, bringing in alike—and our concern is that is not happening on this—on the Biologics Price Competition and Innovation Act, and those concerns.

So if you would take that for suggestions, and if you want to come back and follow up on a lot of these issues, we would be happy to talk with you again. I do appreciate you reaching out personally, and I look forward to working with you.

Secretary BURWELL. I do appreciate this issue of stakeholder input. We think it is important to making sure we get this right.

Mr. SHIMKUS. Thank you very much.

Mr. PITTS. Chair thanks the gentleman. Chair now recognizes gentlelady from California, Ms. Matsui, for 5 minutes for questions.

Ms. MATSUI. Thank you, Mr. Chairman. Secretary Burwell, thank you for being here. I want to talk about mental health. When we think about health, we need to consider the whole person. Mental health has historically taken a back seat to physical health, but the head is connected to the body, and one affects the other.

I have been working for years with my colleagues on both sides of the aisle, and both sides of the Capitol, to make changes to fix our broken mental health system. And as you know, a demonstration project based on the Excellence in Mental Health Act, that I co-authored with my colleague here, Congressman Lance, into law last year, and I look forward to working with you and the Administrator to make sure this is implemented properly, and in a way that states can demonstrate success.

I also look forward to working with you to make further changes and improve our mental health system. I was pleased to see that the budget will eliminate Medicare's 190 day mental health services more in line—and keep that more in line with physical, for which no limit exists. Can you briefly talk about that policy, and how it would benefit seniors and people with disabilities who need psychiatric services?

Secretary BURWELL. Our overall approach in the mental health space, and it is one that we consider a priority, is to try and get, in terms of both care and payment, to parity with how we think about other health issues. And there are steps that we are taking throughout the budget, and whether it is the implementation of the piece of legislation that you referred to, and the issue that your colleague just raised about stakeholder engagement, and making sure we are getting that input as we implement. So we are implementing, and thinking about the policies to promote behavioral and mental health through our payment system, and making sure that there is parity. That seems to be something that is been important.

We are trying to focus on access, because many people—the question of access to the right types of providers, in terms of behavioral

health, that is something you see in some of our now is the time budgeting work, in terms of making sure that SAMSA and others are ensuring that we have providers. And then there is access, and that is an issue for all people of all ages, but especially young people getting the access that they need.

So as we think about all the pieces working together, about the funding, about the access, and then that there are providers that can provide.

Ms. MATSUI. I appreciate that, and as we move forward, there is a continuum of mental health issues that we need to address. And it is a complicated issue, and we would certainly like to work with you as we move forward on that.

And now I would also like to talk about seniors, because that is a special interest area of mine too. And, as we consider changes to the Medicare program, our first priority should always be seniors, especially knowing that seniors spend about 14 percent of their household income on health care costs, compared to five percent—households who do not have a Medicare beneficiary. And we need to find ways to save money in the Medicare program, and we have been, but not by cutting benefits, but by re-aligning incentives to improve outcomes in patient care. If a senior gets the right care at the right time, it is not only better for the senior, but also saves the system a lot of money.

Now, I appreciate some of the provisions in the budget, and I would like to discuss these further with you. The budget seeks to save money by restoring drug rebates for the dual-eligible population on Medicare. Secretary Burwell, can you please elaborate on that?

Secretary BURWELL. In terms of the dual-eligible——

Ms. MATSUI. Yes, right. The drug rebates for dual-eligible population.

Secretary BURWELL. One of the things that—the dual-eligible population has two elements to it. Is both a very complicated population——

Ms. MATSUI. Yes.

Secretary BURWELL [continuing]. Because they are people who have a number of different conditions that are being treated in different ways. It is also a very expensive population. And as we work to improve both the quality and affordability of the care, that is what we are trying to do, as we look at these proposals. And it is all a part of the broader issue of delivery system reform, which you touched on a little bit, and we have set out clear goals.

For the first time ever we have said that in the area of Medicare, that by 2016 we have set a goal that 30 percent of all payments will be in different payment systems, where we are not paying for volume, but paying for value. And as a part of—we move forward to this change system, we want to do that. That is about price, but it is also about quality, and this is a proposal that we are trying to move forward on both.

Ms. MATSUI. And I know that this is going to be difficult because there are areas where you have to look at the budget, but as we look at this, we have to also look at the seniors. And that is really why, when we look at this—I know you seek to increase the skin in the game for Medicare beneficiaries, however, I would argue

that seniors already have a lot skin in the game, and Medicare, and the additional cost sharing, will not bring down costs in the program.

And as you know, as they have increased costs, you look at—most of them are supported by Social Security, and then that—what they do is shift over the costs to pay for their health care from Social Security. So I think it is something we really have to look at more holistically. So thank you very much for everything that you are doing.

Secretary BURWELL. Thank you.

Ms. MATSUI. Yield back.

Mr. PITTS. Chair thanks the gentlelady, now recognizes the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. MURPHY. Welcome here, Madam Secretary. We appreciate you being here. I also want to associate myself with the comments of my friend, Ms. Matsui of California, about mental health, and look forward to working with you on those things.

In a related area, we have had a number of hearings here regarding mental health, and among them has been the Substance Abuse and Mental Health Service Administration. We have asked them repeatedly for information over almost a year for getting some records. Chairman Upton and I have asked for these things. We have not gotten those documents, and we are concerned about their delays. I wonder if you could help us get some assurance that we will get those documents from SAMSA?

Secretary BURWELL. As you and I had the opportunity to discuss, this is something that we are working on, and I am hopeful that very soon you will have some of those documents, and we will continue to work with you on it.

Mr. MURPHY. Thank you. I appreciate your teamwork on this. On another question, when we passed the SGR patch, I think it was last year, there was also a demo project, which is what Ms. Matsui was also referring to, for certified community behavioral health clinics to improve access.

Secretary BURWELL. Yes.

Mr. MURPHY. Now, as part of this, we also attached something for AOT, assisted outpatient treatment, for counties and communities to also have access to some grants to facilitate that, as long as they also were—so those community behavioral health clinics would get those—to also help for those who are cycling through with histories of violence, prison, homelessness, et cetera. That small one percent of one percent that are persistent chronically mentally ill going through the system.

One of the things I want to make sure and find out from you is—the way this was designed is to make sure that only those counties who really have AOT would be eligible for those grant programs, if they are going to attach those to those community health centers. Is that something you are aware of, and can you work with us to make sure that those grant programs are available in that sense?

Secretary BURWELL. We do want to work with you on that, and yes, we are working on that, and would like to work with you to make sure that we do have those standards in——

Mr. MURPHY. Thank you. Another one has to do with a program that was discussed by SAMSA which is called iCare, which is to help with those going into emergency rooms——

Secretary BURWELL. Yes.

Mr. MURPHY [continuing]. To deal with those in crisis. One of the concerns I have, and certainly we have seen headlines, some tragic, sad cases, such as that with the Virginia Senator, Creigh Deeds, his son Gus. The problem is that there are thousands this occurs in this country every year, where there just simply aren't enough psychiatric hospital beds, and so people languish in emergency rooms, often in a five point tie-down, and given chemical sedatives until a room opens up. It could be hours, or days, or weeks, in some cases. We wouldn't have this problem if we had more psych beds.

And so I am hoping that, since the demand for psychiatric beds exceeds the current supply of inpatient psychiatric beds, that is something else you can work with us in legislation to say, we ought to have a place for those in crisis to get stabilized, not go to jail, not sit in a jail cell and languish there, or sit in an emergency room, but work with us on that too? Would you be willing to work with us on that too?

Secretary BURWELL. Yes, looking——

Mr. MURPHY. Thank you.

Secretary BURWELL [continuing]. Forward to that.

Mr. MURPHY. And another issue, then, related to the assisted outpatient treatment grant program as a stand-alone thing, I want to show you—I think I have a poster here of—I just want to show you some of the outcome measures. This comes out of a Duke University study.

Secretary BURWELL. Yes.

Mr. MURPHY. And when you have assisted outpatient treatment, so working with someone from the court, or judge, working with a person, saying, you need to stay in treatment for a number of months, outpatient treatment, not inpatient, take your medication, see this person to report back, like with the mental health court or something, they saw an 87 percent reduction in incarcerations, an 83 percent reduction in arrests, 77 percent reduction in psychiatric inpatient hospitalizations, and a 33 percent reduction in ER hospitalizations. So I just want to show you that too. And, by the way, the costs are cut in half for these folks too.

But there is one that—in working with the issues of CBO scoring, et cetera, we are really going to have to, I think, team up together on this, and say there ought to be some options for people to be in outpatient care. And this is psychiatry, psychology, peer support, social workers, people helping with job training, housing, all those things together, but there has to be this coordination of programs. You will work with us on this too?

Secretary BURWELL. Well—and I think it is part of the broader issue of delivery system reform, and how we deliver quality. You are focused in a very important area, in mental health. When we look at diabetes, in the clinics that I have visited across the country, when we get these adherence numbers up, and people participating, and that usually has to do with coordinated care, and the type of interaction and communication you are talking about, we get adherence, we get less of the disease or problem, and we get

lower costs because the things that happen when we have the bad things that go wrong when people aren't adhering.

Mr. MURPHY. Yes, it is going to require that different view of some things. And I think you may be familiar with the hearing we had in the Oversight Committee 2 weeks ago, where a GAO report identified—I was amazed by this—112 Federal agencies and programs, scattered across eight departments, that deal with mental illness. They said the interagency coordination program supporting individuals with serious mental illness is lacking. It was, to me, a really dizzying and sad description of the process here. I hope you will also work with us as we work to coordinate those programs. And can I have that assurance from you as well?

Secretary BURWELL. We will, and we do coordinate. We coordinate them across the overarching issue, and then within their areas, like veterans' homelessness, and the issues that relate. And so I want to have the conversation about how we think about where we can strengthen those things.

Mr. MURPHY. Thank you. Let us continue work with that. Thank you, Mr. Chairman. I yield back.

Mr. PITTS. Chair thanks the gentleman. Now recognize the gentleman from Oregon, Mr. Schrader, 5 minutes for questions.

Mr. SCHRADER. Thank you, Mr. Chairman. Thank you for being here, Madam Secretary.

Secretary BURWELL. Thank you.

Mr. SCHRADER. Last year health care spending grew at the slowest rate on record since 1960. Health care price inflation is at its lowest rate in 50 years, and the ACA's gotten a lot of attribution by CBO for making a big difference in that result. Have you seen Republican legislative language that would give us that same result?

Secretary BURWELL. We haven't seen a proposal that would continue us on our path with regard to some of the changes we have put in place.

Mr. SCHRADER. Seniors have also benefitted dramatically from the ACA. Prescription drug costs are a big issue for them.

Secretary BURWELL. Yes.

Mr. SCHRADER. Over eight million seniors have actually benefitted from, and saved, over $11 billion, as I understand it, on prescription drugs since the enactment of the ACA. Is there a Republican proposal out there that does a similar thing?

Secretary BURWELL. We haven't seen a proposal that would take care of this issue, the donut hole. And, actually, on Tuesday we actually were able to update our numbers in that space, and it is now $15 billion in terms of the savings. And on average in the country, that is about $1,600 per——

Mr. SCHRADER. I find that ironic, that my colleagues on the other side of the aisle keep asking for a contingency plan from the Administration on this bogus lawsuit, and yet, as a firm believer in Article I, legislative supremacy, with all due respect, Madam Secretary, I think it is our responsibility, and the majority party controls both chambers, where the heck is their contingency plan? That is a rhetorical question, Madam Secretary.

One of the things that has been really good, I think, in my state is the expansion of the Affordable Care Act into the Medicaid popu-

lation and into the private sector. We have had some unqualified success. Emergency room visits are down, like, 21 percent. We have actually gotten hospital admissions, complications from diabetes alone down nine percent, not to mention other diseases. COPD, Chronic Obstructive Pulmonary Disease, hospital stays down almost 50 percent. Are you getting any of the same—those same type of results from other states? What—could you——

Secretary BURWELL. So we are, and recently, actually, in the last 2 weeks, out of the State of Kentucky, we have seen a piece of analysis done by the University of Louisville in Deloitte, and that piece of analysis showed they did it at the beginning of the expansion, and then they did the analysis now. And what the analysis showed is that the expansion will contribute to 40,000 jobs in the State of Kentucky, and will contribute to their GDP by $30 billion. And that is the period to 2021, so that is over a period of time. But we are starting to see both the economic and job impacts, as well as some of the health impacts that you were describing.

Mr. SCHRADER. Well, contrary to popular demagoguery on right-wing radio and TV, this is a marketplace system we set up. Federal Government is the facilitator in that. The state—some of the state exchanges are a facilitator. Like everyone, I think, here, we all believe in the power of marketplace competition. My own state, for instance, over the last year, instead of seeing the double digit increases in insurance premiums on average, ours actually stayed level, or decreased slightly.

That, to me, is a key indicator for the working or non-working of the Affordable Care Act. Our uninsured rate in Oregon went down 63 percent. I have had testimonials from hospitals and doctors about how people actually have health care access at this point in time. Could you talk about what you see nationally in increased competition——

Secretary BURWELL. So with regard to the issue of increased competition, we saw 25 percent more issuers come into the marketplace this year, and so more issuers means more plans and competition.

Mr. SCHRADER. They wouldn't be doing this if they weren't making some money at this, and the program wasn't working, Madam Secretary.

Secretary BURWELL. And so—and also, with regard to the issue of competition, what we know is, in many plans that are employer-based plans, people do not come in and shop. They just automatically re-enroll. And, as you know, we had that as part of the marketplace this year. But we know that, actually, the majority of people came in and shopped. And that, I think, is related to the competition, and it is related to a consumer who wants to make the best choice. And that choice, sometimes based on benefit, that choice sometimes based on cost, and cost has a number of different elements, whether that is premium or deductible.

Mr. SCHRADER. Correct.

Secretary BURWELL. So we are seeing more players come in, and we are also seeing the consumer behave in a way that is indicative that they want that competition and shopping.

Mr. SCHRADER. I would like to call out some kudos on the GME increase in the budget, the money you put in for Medicare appeals.

Back home we do a lot of work, of course, with people that are having trouble navigating the system big time, and the investment in primary care docs. I think that is important.

Quick little comment, the only thing I am a little concerned about is if we are going for bundled payments and increased competition, why we are hammering on the Medicare Advantage plans a little bit?

Secretary BURWELL. As I mentioned to your colleague, I think what we are trying to do is balance, making sure that those plans are good and strong, and we have seen that over the period of the changes we have done. We try and do the changes in a measured way that gets to things that actually have to do with what we believe is strong representation of the taxpayer, in terms of places where we believe there are issues, like up-coding, that is occurring, and that MedPAC has articulated those, and others. We always want to listen and hear, and we want to watch carefully if we are seeing problems that occur with the changes, and to date, we haven't.

Mr. SCHRADER. Thank you, and I yield back.

Mr. PITTS. Chair thanks the gentleman. Now recognize the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. LANCE. Thank you, Mr. Chairman. Madam Secretary, regarding King vs. Burwell, I understand what you have said, that there can be no administrative action should the Plaintiff win the case. You have stated that explicitly, and repeatedly, and that this not my question. My question relates back to the Chairman, who said in his opening line of questioning, that we have a specific source within your department that there is a document related to what HHS might do, should the Supreme Court rule against the Administration. I understand that your point of view is that there can be no administrative action. You have stated that explicitly. Are you aware of any such document? And I am not asking you about your position on administrative action. I am asking about a document in this regard.

Secretary BURWELL. Congressman, if there is this document, and you know of it, I would certainly like to know of the document, because I don't have knowledge of a 100 page——

Mr. LANCE. I didn't say 100 page, now did I?

Secretary BURWELL. Sorry.

Mr. LANCE. I just said a document.

Secretary BURWELL [continuing]. Chairman——

Mr. LANCE. I don't know how many pages it is. You are not aware of any document?

Secretary BURWELL. As I have said, there isn't administrative action——

Mr. LANCE. Yes, I have made that clear that I understand your point of view on that. Is there a document as to a reaction from HHS should the case be won by the Plaintiff in the Supreme Court?

Secretary BURWELL. With regard to a reaction, as I said—because I have articulated that—I want to be careful, because I have articulated——

Mr. LANCE. As I have tried to be careful.

Secretary BURWELL [continuing]. The problems with regard to the question of what will happen, we know how many people are in the marketplace, how many——

Mr. LANCE. Yes. That is filibustering. I understand that. I am asking whether there is any document, we have a source indicating there is a document, as to what might be the response from HHS?

Secretary BURWELL. I am not familiar with the document you are referring to.

Mr. LANCE. And let me say that a former CMS administrator, Tom Scully of, I believe, the Bush Administration has said, of course they have a document. He said, of course they have one, I think he referred to a document, they should all resign if they don't. I would hope that your department, Madam Secretary, would have some sort of contingency plan should the Court rule for Plaintiff. Do you believe that the suit is bogus?

Secretary BURWELL. With regard to the lawsuit, as I said, what I believe is that the law is clear——

Mr. LANCE. Yes, I understand that. Do you believe the suit is bogus?

Secretary BURWELL. That is a characterization. I—my point about the suit is—what I believe is that we hold the right position, and that our position——

Mr. LANCE. Yes, I understand that, and it will be argued next week, and a decision will be made by the end of June. Formerly, when I asked questions about this, not from you, but regarding prior officials, there was the impression that it was a frivolous suit. Do you believe the suit is frivolous or bogus?

Secretary BURWELL. What I believe is that we should continue making progress for the American people on three things that the Affordable Care Act——

Mr. LANCE. Yes, I am aware of that. Do you believe the suit is——

Secretary BURWELL [continuing]. Access——

Mr. LANCE [continuing]. Frivolous or bogus?

Secretary BURWELL. May I finish, Congressman? I believe that we, as the Executive Branch and the Legislative Branch, should be working together on three things we agree with. That is affordability, access, and quality.

Mr. LANCE. I agree with all——

Secretary BURWELL. And what I would hope that we can do is build on the progress that we have seen. And that progress is that 11.4 million people——

Mr. LANCE. Reclaiming my time, do you believe that the Supreme Court is likely rule unanimously on this decision?

Secretary BURWELL. As I have indicated, we believe that the Court will rule in our favor.

Mr. LANCE. Yes. Do you believe the suit is bogus or frivolous?

Secretary BURWELL. With regard to characterization, what I think is valuable is that we believe that our position is the position that will stand, and that we believe we are right. The people in the State of New Jersey should not have their subsidies taken away because they do or don't have a marketplace, when people right across the border in New York will get those——

Mr. LANCE. I believe, Madam Secretary, in equal justice under law, as is inscribed across the street on the Supreme Court building. I believe this is a very serious case. I think it is closely contested. Under no circumstances do I believe that Plaintiff will win nine to nothing. I think there are good arguments on both sides. I have read the briefs, all of the briefs. I have read the Solicitor General's brief. I have read the brief of the Plaintiff. I think it is a very serious case, and you and I may disagree on the case. I respect that, and I understand that.

It is frustrating to me that, here in Washington, there cannot be an intellectual argument as to pros and cons, and I certainly would encourage the Administration to have a contingency plan, and to work with us in Congress, including the Republican majority in both the House and the Senate, should the Court rule for Plaintiff. Thank you, Mr. Chairman.

Secretary BURWELL. Congressman, with regard to the question of our authorities, what you just ended with was the issue of the legislation, and I want to make sure that I touch on that. As we have said all along, we are willing, and look forward to working with the Congress on any legislation that would work on those three things we talked about, affordability, access, and quality, and preserves the economy, and supports working middle class. That is how we will look at legislation. We want to do that now, and we want to do that in any——

Mr. LANCE. And I was part of a group that had an alternative piece of legislation that didn't see the light of day put forth by the Tuesday lunch group, of whom I am a member of that group. It was different from the Affordable Care Act, but it was an alternative piece of legislation. Of course, it didn't see the light of day in any way, shape, or form in 2009 and 2010. Thank you, Mr.——

Mr. PITTS. Chair thanks the gentleman. Now recognize the gentleman from Massachusetts, Mr. Kennedy, 5 minutes for questions.

Mr. KENNEDY. Thank you very much, Mr. Chairman. Madam Secretary, thank you very much for being here. You touched on, a moment ago, about legislation that you said you were eager to work with Democrats and Republicans on. Have you seen any such legislation?

Secretary BURWELL. With regard to legislation that would promote and move forward on those three things, making sure we are expanding that insured population, have not seen things that would work toward that.

Mr. KENNEDY. Madam Secretary, are you aware of how many bills were passed and signed—or bills were passed by the 115th Congress?

Secretary BURWELL. I don't know the exact number.

Mr. KENNEDY. Give or take a few, 931, ballpark, sound about right? Any idea on how many of those bills were signed into law? 296 sound about right? Any idea how many times in my first term in Congress we repealed all or part of the Affordable Care Act? 55 sound about right? Any idea how many times those were signed into law? None.

Secretary BURWELL. None.

Mr. KENNEDY. Are you aware of how many times we voted on some sort of replacement bill to the Affordable Care Act, that we

voted to repeal 55 times, to provide Americans with quality affordable access and financial assistance to access to health care that they deserve? None.

Secretary BURWELL. I think the number is none.

Mr. KENNEDY. OK. I would agree with you. So I think, given all of the discussion we have had over the course of the past several hours about contingencies, about other options, in the time that I have been in Congress, over 55 times in my first term, including another time in my second term, to repeal all or part of the Affordable Care Act, and under the time that I have been here under Republican leadership, to not have a single bill that has seen the House floor to vote on an alternative to provide quality, affordable, accessible health care to millions of Americans, I would respectfully ask, as my colleagues have, for the Administration to work with Democrats and Republicans to work on any such legislation, should they decide to bring that to the light of day.

Secretary BURWELL. And in our budget, I would just like to mention we actually do have a proposal to improve the small business provisions of the Affordable Care Act, to try and both simplify and make the tax credits better for small businesses. That is feedback we have received about that, and that is something that is included in our budget.

Mr. KENNEDY. Now, turning to a couple—well, hopefully more substantive questions that I can get to with you, Madam Secretary, I was pleased to see that the Democratic CHIP reauthorization bill, that the was included in the President's budget extended the Medicaid primary care payment increase. The rate of increase that was initially included in the ACA has been absolutely critical, and for the last 2 years, it has boosted payments to doctors who treat the most vulnerable populations, making access an attainable goal, not just an aspirational target.

According to a recent report from the Urban Institute, however, the expiration of that payment bump at the end of last year will result in Medicaid provider payments that are going to be cut on average of 43 percent, and over 50 percent in some states. The impact on wait times could be drastic and immediate. I was hoping, Madam Secretary, you might be able to comment on the importance of parity between Medicare and Medicaid payment to our primary care providers, and when they have to choose between seeing some of most vulnerable populations like seniors, pregnant women, and children, why would there possibly be a reimbursement discrepancy?

Secretary BURWELL. So, I think, as you are indicating, why we have proposed the continuation of these payments is because we believe it is making a difference, and it is making a difference to the access and coverage that people are getting in the system. And so we have proposed it as a continuation, and we hope that that is something that the Congress will consider and support.

Mr. KENNEDY. Thank you. The second topic that I want to touch on today, actually, my colleague, Mr. Murphy, touched on it quite extensively in his comments, but it is about substance abuse and mental health. Back in Massachusetts, Madam Secretary, I see communities on the front lines of a growing and extraordinarily devastating opiate abuse crisis, and we are looking to the Federal

Government for some support as prescription drug abuse, and a number of heroin overdoses, continue to mount.

Madam Secretary, I was a prosecutor before I ran for office. I saw the impacts of this on a daily basis, not just in terms of addiction and people needing treatment, but in terms of property crimes, personal crimes for folks that are looking to try to find a way to get help, but the treatment options just aren't there. There are not enough doctors. There are not enough beds, as Mr. Murphy indicated. There are not enough wrap-around services. There are not enough care. And I was hoping that you might be able to touch on the importance of actually creating these incentives through Medicaid largely, which is our largest mental health provider, to actually make sure that—not just another grant program, but to make sure the incentives are in place to allow that marketplace to provide that care?

Secretary BURWELL. So the bad news is, as you indicate, there were 259 million prescriptions for painkillers, opioids, during 2012. That is more than one per adult in the Nation. That is the bad news. The good news is that I believe that there is bipartisan support for us to do something, and I believe that that is both in the Executive and Legislative Branch here in Washington, D.C., as well as with the governors, who I met with over the weekend on this issue.

I think with regard to payment, it is an important place, but there are three fundamental things that we believe we need to work with the Congress and work with the governors to do. One is, in terms of the prescribing, that is at the root of much of the problem. We have seen progress in states like Florida, where they are watching the prescribing. The plans that states can put in place to oversee that is an important part, but we have a part two. Second is the issue of things like—and access to those, which I think gets to some of the payment issues. And the third is making sure there is medical treatment, and I think that was the third part of what you were mentioning. Those three elements, I think, is—that is a basic agreed upon.

And whether it is Senator Portman and Senator Widen, or Mr. Rogers, or—it is across the board. There is bipartisan support because states from Massachusetts to Kentucky, and West Virginia, my own home state, are suffering in devastating ways. And the one piece you didn't mention, which is the economic impact. And, having come from a large employer like Walmart, what it means in terms of having an employee base that can pass a drug test.

Mr. KENNEDY. Thank you, Madam Secretary.

Secretary BURWELL. Thank you.

Mr. PITTS. Chair thanks the gentleman. Chair will note that we have just been joined by a group of students from the Houston area. The Ranking Member has informed me—you want to say anything, Gene?

Mr. GREEN. Mr. Chairman, I would just like to recognize a number of our chiropractic students from the Houston area, and Dr. Mossad, who actually retired as the president of our chiropractic college in Pasadena, Texas. And I invited them last night because I wanted to show how the health care policy is made in the health care subcommittee. Thank you, Mr. Chair.

Mr. PITTS. Thank you. You are certainly welcome to be here. And the Chair now recognize the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman, I appreciate that. Appreciate the students being here. We may have some disagreements today, but I will tell you that the Ranking Member, Mr. Green, and I worked very hard on a health care bill that was signed into law last year, so no matter what you may see today, we do get along more often than the press lets you know. All right.

That being said, Madam Secretary, in response to a previous question, you indicated you weren't aware of any of the laws being signed in. I am sitting here with a CRS report, Congressional Research Service, indicating that there are 12 bills that repealed parts of Obamacare that were, in fact, signed into law. You are not aware of that, is that correct, in relationship to your previous answer?

Secretary BURWELL. With regard to the specifics of the answer, those were repeal questions, I thought.

Mr. GRIFFITH. Yes, and this was part——

Secretary BURWELL. Full repeal.

Mr. GRIFFITH. He said——

Secretary BURWELL. Full repeal was——

Mr. GRIFFITH. He said full or a part. So you were mistaken, and weren't aware of these 12 that were partially repeals?

Secretary BURWELL. I was referring to the issue of full repeal.

Mr. GRIFFITH. But you are aware of these?

Secretary BURWELL. I would have to look and see——

Mr. GRIFFITH. OK. And if I could just have this entered into the record, I would appreciate——

Mr. PITTS. Without objection, so ordered. [1]

Mr. GRIFFITH. Thank you, Mr. Chair. Also, are you familiar with my H.R. 130?

Secretary BURWELL. Apologize, don't know what that bill is. Maybe if it is described I might——

Mr. GRIFFITH. And are you—it is a bill that deals with the black lung provisions of Obamacare.

Secretary BURWELL. I am not familiar with that——

Mr. GRIFFITH. I appreciate that. Are you——

Secretary BURWELL [continuing]. Legislation.

Mr. GRIFFITH [continuing]. Familiar with my H.R. 790, which is the Compassionate Freedom of Choice Act?

Secretary BURWELL. Not familiar with the specific names of the legislation——

Mr. GRIFFITH. And I appreciate that. And are you familiar with H.R. 793, which deals with preferred pharmacy networks and Part D?

Secretary BURWELL. Depending on a——

Mr. GRIFFITH. Another one of mine.

Secretary BURWELL [continuing]. Description, that may——

Mr. GRIFFITH. And so the reason I ask those questions is—been very well orchestrated today, from a political standpoint. The other

[1] The report has been retained in committee files and is also available at *http://docs.house.gov/meetings/if/if14/20150226/103028/hmtg-114-if14-20150226-sd008.pdf.*

side of the aisle has asked you repeatedly are you aware of Republican legislation that deals with the issues that we are dealing with related to Obamacare? I would submit to you that, in some way or another, the three points that you pointed out, each one of those bills did. You are not intimately familiar with them, and I understand that, and I am not blaming you, because you have been put into that unenviable position that sometimes happens, where there is a difference between negative evidence, and a lack of evidence. And what you presented today is a lack of evidence, and I appreciate that.

That doesn't mean that these bills don't exist, just as I gave you the numbers on those three. It doesn't mean that there aren't other bills that other members have that are out there that are Republican proposals to take care of the American citizen while we are in the process of repealing Obamacare. And so you are just submitting that you are not aware of it, but there are, in fact, bills out there that may be doing that, and also further discussions behind the scenes that may be doing that that you are unaware of. Isn't that correct?

Secretary BURWELL. Would welcome—there was a veterans' bill that we all agreed on. The firefighters, I haven't——

Mr. GRIFFITH. I am just saying, though, that——

Secretary BURWELL [continuing]. Legislation——

Mr. GRIFFITH [continuing]. When you say, though, in the answer to any number of members on the other side of the aisle that you aren't aware, that doesn't mean they don't exist, it just means you are not aware, am I correct? Yes? All right, we will move on.

The President's fiscal year 2016 budget calls for 92 million for the Office of National Coordinator, ONC, for purposes including the transition to a governance approach for health information exchange. In 2012, an HHS request for information noted that Congressional authorities granted to the ONC in the 2009 High Tech Act would support this governance mechanism. Madam Secretary, I hold in my hand a copy of a Congressional Research Report dated January 7, 2015 that suggests ONC does not have the authority to support the ONC governance structure outlined in the President's budget. Don't you agree that when agencies take action they should be supported by congressional authorization?

Secretary BURWELL. Not familiar with the report, would welcome seeing it. With regard to the Office of the National Coordinator, I think you know we just came out with the plan to continue moving us towards electronic medical records. We back that up with specific things. We continue to work on something that cuts across many of the issues, and whether it is——

Mr. GRIFFITH. But you would agree with the principle, that there ought to be congressional authority for an agency to take action, would you not? Yes or no?

Secretary BURWELL. I would agree that we——

Mr. GRIFFITH. Yes, ma'am.

Secretary BURWELL [continuing]. Need——

Mr. GRIFFITH. And, Mr. Chairman, if I could also have that Congressional Research Service report placed into the record, I would——

Mr. PITTS. Without objection, so ordered.

Mr. GRIFFITH. As a part of its governance push, ONC awarded a contract to RTI to develop its Health IT Safety Center. RTI said at the time of the award that it would define the focus, functions, governance, and value of the national health IT safety content. I am just concerned, as I pointed out a minute ago, that when you have these comments being made—now, we haven't seen it yet, and the report that I just had entered into the record shows we haven't seen the final analysis of what they are going to do, but when you have comments that they are planning to work on governance, and they don't have that authority, I am concerned, when the experts are telling me, both legal and otherwise, that this agency is going beyond its scope of authority, that this is a problem in this Administration, and that we should be careful that we have any agency moving forward without congressional authority.

I am going to ask you to work with me as we move forward on this. I am going to follow up with some questions and some other things, and ask that you work with me to make sure that the ONC does not overstep its authority granted to it in legislation by this Congress.

Secretary BURWELL. I would like to work with you to understand, and understand what these concerns on governance are. This is new to me, and so I would like to——

Mr. KENNEDY. Yes, ma'am.

Secretary BURWELL [continuing]. Understand further what the concern is.

Mr. GRIFFITH. And I appreciate that, and I yield back. Thank you, Mr. Chairman.

Secretary BURWELL. Yes.

Mr. PITTS. Chair thanks the gentleman. Now recognize the gentlelady from California, Ms. Capps, 5 minutes for questions.

Mrs. CAPPS. I thank my Chair—colleague for yielding me time, and I do have a different topic to discuss with you, Secretary Burwell, but my colleague from Texas has asked for 10 seconds.

Mr. GREEN. I will do my 10 seconds. I want to thank the Congressman from Virginia, but I think the clarification is that up until Congressman Kennedy, all our statements were repeal the Affordable Care Act without an alternative. Now, there were bills that were passed, and none of us—up until——

Secretary BURWELL. That is right.

Mr. GREEN [continuing]. Congressman Kennedy, but there is no repeal and replace. There is only repeal for 56 times. And thank you for——

Secretary BURWELL. And that is why I responded to full repeal. It was——

Mrs. CAPPS. I want—thank you. You know, I want to go back to the President's budget this year, which I think, on the whole, strikes an important balance between controlling spending and promoting public health. These public health topics are what I want to bring to your attention.

I was pleased to see that there was continued support for nursing workforce development. I believe, and I know you did too, a strong nursing workforce improves the health of our communities, as well as the quality of the health care system. And we now have the significant challenge in our Nation of caring for a growing pa-

tient population with limited resources. And I am a nurse, so I know that we can't reach our health care goals without a strong health care workforce made up of a range of health care professionals. And these are the development programs, such as Title 8, that are proven to be a solution that can help address this challenge.

And so would you please discuss briefly, because I have two more topics, what this budget request does to make sure that we have a diverse health care workforce, well equipped, and large enough to meet our needs?

Secretary BURWELL. I will just be very brief——

Mrs. CAPPS. Sure.

Secretary BURWELL [continuing]. Which is, I think one of the core and anchor places that we do that is making sure that we are funding our National Health Service Corps. And the increases that we have asked for are a very important part of that across, and it is especially important because we serve that group of people—30 percent are diverse in that——

Mrs. CAPPS. Yes.

Secretary BURWELL [continuing]. Group. And in the Nation as a whole, the number is 10 percent, so we are over-indexing for that, and we think that is a very important place.

Mrs. CAPPS. Right.

Secretary BURWELL. I will stop. There are other things, but I want to——

Mrs. CAPPS. Right, because this one that I am going to mention is near and dear to my heart, and that is the maternal, infant, and early childhood home visiting programs. Such bang for the buck that you get with this. If you have ever seen it as I have, been part of one, it is such a proactive and preventive service. And there is an increase in commitment in this home visiting program in the budget for 2016. These are evidence-based, as you know, bipartisan programs, helping to ensure that all children across the board get an opportunity to be healthy and successful. And they are so critical to improving health outcomes for both women and children and families.

So my question is how increased funding for these programs is going to address disparities and improve the health? How can we make it better?

Secretary BURWELL. So with regard to this issue, because I am a mother of a 5- and a 7-year-old, I have——

Mrs. CAPPS. There you go.

Secretary BURWELL [continuing]. Learned the importance of that information very recently, in terms of being able to give your children what they need. And so the program that you are describing, and why we think it is important to continue on the pace, it is an evidence-based program. We have seen——

Mrs. CAPPS. Yes.

Secretary BURWELL [continuing]. The results in terms of reading, and other analytical skills, up to 12 years old, in terms of the benefits. That is as far as it has been tested. And we see that has happened. When we give mothers and parents that opportunity to get the information they need in home——

Mrs. CAPPS. Yes.

Secretary BURWELL [continuing]. When you go to them, it is making the difference. And so we believe this is a very important part, and part of a continuum that you see in the budget. That home visiting, next comes to that early child care, and making sure that we fund child care so working Americans can be a part of that. And then the issues of Head Start, and improving Head Start, both in terms of the length of day, the time of year, and the quality that we require. So it is a continuum in terms——

Mrs. CAPPS. Yes.

Secretary BURWELL [continuing]. Of making sure we are taking care of those children along the way for working families, and pressing ourselves to improve quality.

Mrs. CAPPS. Right. And, to build on that, and the focus on children and family, this question was asked about graduate medical education, but I want to focus on children's hospital GME, because children's hospitals programs are so critical for training pediatricians, pediatric specialists, and pediatric researchers. It is less than one percent of hospitals. They train 51 percent of all pediatric specialists, and the children's hospital graduate medical education programs currently receive much less funding than other, you know, children don't lobby. We have to do this on their behalf. And would you explain the proposed changes to funding for children's hospital graduate medical education programs, and what steps are being taken to ensure that we are meeting the demand for pediatric care?

Secretary BURWELL. We want to meet that demand, and we want to meet that demand for both primary care, and the specialties where we don't necessarily have the number of practicing physicians that we need. And so the proposal that we have tries to respond to the criticisms that we received last year with our proposal, and that there is $100 million that is dedicated firmly to the children's programs. In addition to that, they are able to compete. Right now what we do is we cover the direct costs, but we don't continue to cover the indirect cost.

Mrs. CAPPS. Thank you very much.

Mr. PITTS. Chair thanks the gentlelady. Now recognize the gentleman from Texas, Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman. Again, Madam Secretary, my apologies for being out of the hearing, at another hearing. And I also apologize for not having the President's budget here with me this morning. But the President did outline a number of savings in the Medicare space in the Presidential budget, is that correct? Do I understand——

Secretary BURWELL. Yes.

Mr. BURGESS [continuing]. That correctly?

Secretary BURWELL. That is correct.

Mr. BURGESS. And in general, as the head of HHS, are you supportive of those proposals in the President's budget?

Secretary BURWELL. Yes.

Mr. BURGESS. Let me ask you a question, then. You know that one of the things—I mean, I have just been pounding my head against the wall for 12 years on the sustainable growth rate formula. We were very close last year. We almost cracked the nut, but we didn't quite get there. But I thought we had a good proposal, and we are very close to introducing the same policy language

again in this Congress. Offsets have been difficult, as everyone would expect.

So let me just ask you, those savings that the President identified, those Medicare savings that the President identified in the Presidential budget, do you think it would be a good idea to apply those savings toward the permanent repeal of the sustainable growth rate formula?

Secretary BURWELL. With regard to how we pay for it in the President's budget, it is within the baseline, and we include it that way. With regard to the specific question of just using our approach to the Medicare, those savings are part of a broader context. It is a budget, and we put the budget together in its entirety. We view that those savings need to be paired with other elements of the budget.

Mr. BURGESS. But to the extent that those savers are identified, and those offsets are identified in the budget, it seems to me that would perhaps be a reasonable place to begin the discussion of what are the offsets that are used to put in place for the permanent, universal, complete, forever repeal of the sustainable growth rate formula.

Secretary BURWELL. First, I want to agree with the concept that we are talking about. In my opening remarks, I specifically said that we support the bipartisan, bicameral concepts that were put forward, and so on that we agree. With regard to the question of offsets, why I started with how we do it, which is building it into the baseline, is because that is the way we believe it should be done, and that uses the balance of things that we use to pay for things in our entire budget.

So, in terms of where we start, and what we believe, we believe that it needs to be a range of things, and not simply focused on those.

Mr. BURGESS. Yes, but at the same time, as you know, the difficulty with the sustainable growth rate formula is the budget baseline, and the fact that it was built in years ago, and it accumulates over time. It is never corrected, even though a number of patches have been passed by Congress. We basically paid for this damn thing at least 1.4 times——

Secretary BURWELL. I am——

Mr. BURGESS [continuing]. Over the past 12 years. Again——

Secretary BURWELL. Yes.

Mr. BURGESS [continuing]. I just want you to know that. I like the fact that the President put forward cost savers in his budget. Fair warning to you that these are where I am going to go. The lack of participation and people who are willing to come forward and talk seriously about offsets leads me to go the President's budget as the only place I can go for Democratic ideas for an offset. And that is the critical missing piece in getting this SGR settled.

Secretary BURWELL. I think your colleague, Mr. Pallone, actually mentioned his specific idea for this when he spoke to this issue. And you may disagree with that, but that was in terms of contributing to the debate.

Mr. BURGESS. And my door is always open to Mr. Pallone, and I await his invitation, and I will be glad to come to his office.

Let me ask you a question. I know you probably are tired of hearing about King vs. Burwell, but I will bring it up yet one more time, since I haven't been here, it is not exhausting to me yet. On the whole concept around contingency plans, the American Academy of Actuaries, is concerned because insurance companies are supposed to disclose the data upon which they are basing their rates in May, but there could be something that changes the equation in June. So, to the extent that the insurance companies are having to deal with an unsettled future, I mean, they are going to have to deal with contingency plans, are they not? Why should the Department not have a contingency plan, as recommended by the American Academy of Actuaries?

Secretary BURWELL. So, with regard to things that I have authority to plan for, I will plan for. In the current budget that you see in front of you, the unaccompanied children issue, one that I know is a difficult issue, and that there is controversy around, we have put in monies to plan up to 60, have asked for a contingency fund in case. We don't believe it will, but in case the numbers—where there are places that I can plan, we will.

With regard to this issue, while the letter was simple, it actually gets to the core and the fundamental. We do not believe we have administrative authorities—if the Court makes a decision, and as I want to always repeat, we don't believe the Court will decide this way, but if the Court makes a decision and rules for Plaintiff, and says that those subsidies are not available, we don't believe we have an authority to undo the damage that would then occur, which is subsidies go away, individuals can no longer pay. They go off of their insurance, they become uninsured, it drives premiums up in that marketplace. They become uninsured, there is indigent care, it goes up.

We don't believe that we have an authority. It is the Court, makes that decision at that level, that we have an authority to do it, and therefore that is why you are not hearing a plan. It is because we don't have an authority.

Mr. BURGESS. Well, I think you have to agree it will change the structure of the risk pools for the insurance companies. And, Mr. Chair, for that reason, I would like to submit the letter from the American Academy of Actuaries for the record. And I will yield back.

Mr. PITTS. Without objection——

Secretary BURWELL. I do think, though——

Mr. PITTS [continuing]. So ordered.

Secretary BURWELL [continuing]. That is why one does see those companies filing their briefs that they had filed in the case, that articulate the point you are making.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. Gentleman yields back. Chair recognizes the Maryland, Mr. Sarbanes, 5 minutes for questions.

Mr. SARBANES. Thank you, Mr. Chairman. Thank you, Madam Secretary. First, thank you for stepping into public service as you have done. Your tenure at OMB, and now at HHS, is, I think, a real service to the country.

I wanted to talk about this concept of full repeal, which has been a drumbeat for years, it seems, now from the other side of the

aisle, to understand the implications of a full repeal. And so I wanted to go through some of the things that were part of the ACA, and ask you—and it may not be that every one of them is jeopardized by a full repeal, but I think certainly some of them are, the ACA included a measure that would allow young people to stay on their parents' health care up to age 26, and I think upwards of three million younger adults have benefitted from that. If there was a full repeal of the ACA, would that benefit and provision be in jeopardy, do you know?

Secretary BURWELL. It was part of the original Act, so yes.

Mr. SARBANES. Then there was an effort to begin closing the donut hole on prescription drugs under the Part D program, which has bedeviled many of our seniors, who kind of fall into that doughnut hole, often at a critical stage, in terms of needing to access prescription drugs. And the ACA reform included an effort that is begin, it is underway, to close that doughnut hole. Would that be in jeopardy if there was a full repeal?

Secretary BURWELL. It would, and the $15 billion in savings that those seniors have received to date would stop.

Mr. SARBANES. Right. Then there was terrific provisions, in terms of benefits and reimbursement. So, on the benefits side, for Medicare beneficiaries, you had more preventive care being covered fully, eliminating co-payments for certain kinds of preventive care, screening for annual wellness visits, et cetera. That was part of the ACA. A full repeal, I imagine, would jeopardize that reform as well?

Secretary BURWELL. Yes, and we actually just were able to have the numbers, and we have seen an increase in the number of seniors that are using that preventative are. And the percentage of seniors that are using at least one preventative service continues to go up.

Mr. SARBANES. Excellent. We put in some enhanced payment and reimbursement for primary care physicians, recognizing that we need to make sure we are incentivizing that part of the profession, in terms of getting into the pipeline, and also having the opportunity to spend more time with their patients, and have there be some economic rewards for that, which the patients themselves also want. I presume that that would be a peril with a full repeal as well?

Secretary BURWELL. A full repeal would imperil.

Mr. SARBANES. What about the provisions that have eliminated discrimination based on pre-existing conditions? Of course, we have started right out of the gate eliminating that discrimination in the case of children, now that is been expanded more broadly. But I imagine that also would be undermined by a full——

Secretary BURWELL. It——

Mr. SARBANES [continuing]. Repeal?

Secretary BURWELL. It would, and, having had the chance to meet a young woman who had cancer when she was 7—when she was 12 years old she first had colon cancer, and then had thyroid cancer later, and now is in her 20s, and was engaged, but not continuing her graduate education or getting married because her focus was paying for her health care. And now the opportunity to have affordable care—because she had a pre-existing condition, ob-

viously, is now allowing her to go on with her life. The issues of health security are very important, but for many individuals, the financial security is as well.

Mr. SARBANES. Thank you for those comments. The medical loss ratio requirement that now requires insurance plans to direct more of the insurance premium dollar to care, as opposed to overhead costs and so forth, that was part of the ACA, adhering to a particular standard. That would be eliminated, I would expect, in a full repeal?

Secretary BURWELL. In full repeal.

Mr. SARBANES. Subsidies and tax credits for small businesses who want to do the right thing and provide health care coverage for their employees was part of the ACA, so small businesses would be impacted by a full repeal, in terms of their ability to offer that kind of benefit to their workers, isn't that correct?

Secretary BURWELL. It would take away the tax credit if it were a full repeal.

Mr. SARBANES. So even before we get to a discussion of the pros and cons of the health exchanges, which have now offered up coverage to millions of Americans, there are so many other reasons, in addition to that, that we wouldn't want to repeal the Affordable Care Act. Thank you very much for being here. I appreciate your testimony.

Secretary BURWELL. Thank you.

Mr. PITTS. The Chair thanks the gentlemen. Now recognize the gentleman from Florida, Mr. Bilirakis, for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman, very much. Thank you, Madam Secretary for your testimony. Thanks for your appearance, welcome. I want to talk about Medicare Advantage. According to 2012 data, there were about 145,000 seniors in my district. About 40 percent of them are on Medicare Advantage, a little higher than the national average. They love their plans, and they want to keep their plans. They love their benefits, and their choices. Unfortunately, this Administration may not love Medicare Advantage as much as my seniors.

The actuarial firm of Oliver Wyman did an analysis of the proposed 2016 Medicare Advantage rate notice. Reading the report, I am troubled to learn that it estimates that the combined impact of cuts from 2014 to 2016 will cost seniors on an average of $60 to $160 a month, or as much as $1,920 a year. Many of the seniors in my district live on a modest income—fixed income. Why is the Administration forcing many seniors to pay more than $100 a month to keep the plan they like?

Secretary BURWELL. So, with regard to the issue of Medicare Advantage, first I want to say we think the program is a good program. During the period when changes have been enacted, we have seen the program expand by, I think, well over 40 percent. We have seen a number of Medicare Advantage plans that have the top two ratings go from 17 percent to 67 percent. And we have seen that premiums have not been increasing, in terms of the changes that we have done to date.

Why we are proposing these changes is they have been recommended by MedPAC and others with regard to over-coding that is occurring, and as part of our efforts to make sure we are using

the taxpayer dollar wisely. We want to promote the program, we want to keep the program healthy, but we also believe that there are opportunities for those who may be not using the system as well as they might. And that is what our changes are about, and that is what we are trying to do, preserve and build the system, but make sure we do it in the fiscally responsible way.

Mr. BILIRAKIS. Thank you, Madam Secretary. Many seniors who like the Medicare Advantage program they have are going to lose it in the following years. In fact, a recent—Milliman report details a nearly four-fold increase in the number of U.S. counties that no longer have Medicare Advantage as an option, growing from 55 counties in 2012 to 211 counties in 2015. Isn't it concerning to you that seniors are losing the ability to choose a Medicare plan that provides high quality and coordinated care? This is a very successful program, and, again, this is extremely important to my constituents.

Secretary BURWELL. Agreed that it is a very important program, and we want to make sure that it continues, want to see the studies and the underpinning of that. The most recent numbers that I have seen are that 99 percent of beneficiaries have access, and so those numbers may not align with that most recent study, and I want to understand what the difference in that is.

Mr. BILIRAKIS. Thank you, Madam Secretary. One more question. The impact of seniors to Medicare Advantage, according to Oliver Wyman, could result in seniors losing access to their current coverage, or facing higher premiums, reduced benefits, and changes to their network as a result of the proposed cuts. When I talked with seniors in my district about Medicare Advantage, again, they believe the Medicare Advantage model offers high quality coordinated care. Yet further cuts will disrupt the benefits upon which millions of seniors rely.

Your agency likes to tout the so-called affordable premiums and better consumer choices under the Affordable Care Act, but when it comes to Medicare Advantage, why is the Administration pursuing policies that would increase premiums and reduce choices for seniors? And, again, this is very concerning.

Secretary BURWELL. I think the responses with regard to the issue that we have seen, with the changes we have done to date, have not had the premium pressure that is described. We want to continue to watch and monitor. And also that we have seen more people enter in, and the quality improved. And so that is what we have seen to date. We want to continue to work and monitor. We want the program to succeed. We want to support it, and we want to try and do it in the way that is the most fiscally responsible.

Mr. BILIRAKIS. Well, thank you, Madam Secretary. I appreciate it. I yield back, Mr. Chairman.

Mr. PITTS. Chair thanks the gentleman. Now recognize the gentleman from California, Mr. Cardenas, 5 minutes for questions.

Mr. CARDENAS. Thank you very much, Mr. Chairman. Appreciate the opportunity to have this public dialogue for the benefit not only of the members, but for the public as well.

Preserving access to prescription drugs that work for every senior is important, I think, to everybody on this dais, and I think every person who cares about a senior in this country, which prob-

ably makes everybody. So my question has to do with what proposals in the President's budget would increase access for seniors?

Secretary BURWELL. With regard to the specific access for seniors, across the board on prescription drugs, I think, in terms of the programs, whether that is the way we use some of the programs we have just been discussing, but I also think one of the most important things that has happened is that seniors have access to preventative services that they historically may not have. And just announced on Tuesday that what we are seeing is, because the seniors have that access to those preventative services, they are increasing the use of that.

I think throughout our budget one the things we are attempting to do is work very hard to do a delivery system reform, which means getting better quality at a better price for the Nation. And I recently announced, about 3 weeks ago, that in the Medicare space, we are going to try and move to 30 percent of all Medicare payments will be in new payment models, payment models that are about improving that quality and reducing that cost. And so those are some of the areas that I think the budget focuses on this.

Mr. CARDENAS. Now, that effort, is it likely to create an environment, individual by individual, that is likely to increase their quality of extended life versus—because when we are talking about access to preventative care, that means that if you catch something in its early stages—we all know what today's modern medicine, and opportunities—you can actually thwart it, or actually overcome it, versus finding something late in stages, it might even take your life, correct?

Secretary BURWELL. And across the department there are a number of investments that get to that, and whether that is the NIH investments in research, or in the Center for Innovation in Medicare and Medicaid, one of the things where we have out—a proposal that we are getting response to has to do with hospice and curative care, and how to combine those two in a way that will maximize for the quality of the patient. And so it is throughout the budget these issues of cost and quality are things that we focus on.

Mr. CARDENAS. Thank you. On that note, I would also like to add for the record, if you would allow me unanimous consent, Mr. Chairman, to submit a letter for the record from my office that lays out the issues that we are discussing at the moment.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Secretary BURWELL. Thank you.

Mr. CARDENAS. I keep hearing a lot from some of my colleagues about their constituents losing choices. But, then again, one of the things that—it is my understanding, please clarify, that when people are talking about losing choices, they may be describing policies that were, in fact more expensive on the front, and perhaps didn't have minimum benefits standards to the person paying. Is that, in many cases, what people are describing when people are losing choices?

Secretary BURWELL. It can be. I would want to understand the specific——

Mr. CARDENAS. And that is why I say the word maybe——

Secretary BURWELL [continuing]. In the marketplace.

Mr. CARDENAS. Maybe, yes.

Secretary BURWELL. Within the marketplace, there are 25 percent more issuers, which means more choice. The essential health benefits do important things, I think, as you are reflecting, and they get to some of the issues that Mr. Murphy and Ms. Matsui—on mental health. And having those benefits be clear and incorporated is extremely important. So, without understand the specific case, I think it is a little hard to know.

Mr. CARDENAS. But there are, in fact, in some areas where certain kinds of policies are not allowed, but that was—that is based on a new minimum standard, correct?

Secretary BURWELL. That is correct.

Mr. CARDENAS. And one of the things that I have discussed with some of my constituents, and my staff, and some of the providers, and experts that we pulled together, we registered at least over 1,000 families. And I personally tried to speak to as many of those individuals as possible. And what was sad is many of them were even scared to be there. They were thinking about this big Obamacare dragon that was going to obliterate either their finances or their health care.

But what—almost to a person, every person that got up from—once they sat down and figured out what was available to them, or what have you, had a big smile on their face, and they were very pleased, and very relieved, and glad they came. And in one instance I was talking to a gentleman who was paying $60 a month. He was making $9 an hour, single income family. He had a wife and a daughter, and I met all three of them. And when he was done, he had a big smile on his face. He almost got up and left when he met me. But when he was done, he actually realized that he now was able to provide for his family without having to spend $60 a month, and now his entire family has coverage. So I think that is a perfect example of what this is—what is good in the Affordable Care Act.

Thank you, Mr. Chairman. I yield back my time.

Mr. PITTS. Chair thanks the gentleman. Now recognize the gentleman from Indiana, Dr. Buschon, 5 minutes for questions.

Mr. BUSCHON. Thank you, Secretary Burwell, and thanks for coming. And, first of all, I want to thank you for working with Governor Mike Pence of Indiana on Health Indiana Plan 2.0, which will help to cover 350,000 low income Hoosiers in a state-based program that, I think, has been shown historically to not only save money, but is very popular with the enrollees, so thank you very much for that work.

Before I came to Congress, I was a cardiothoracic surgeon, and I treated most of my patients for many weeks after their surgery. And, as you probably know, that falls under a global payment, a 90-day global surgical payment by CMS. Now CMS wants to repeal that rule, and eliminate global payments for surgical services. Why?

Secretary BURWELL. With regard to our understanding of how the global payments are used, the reason that we want to do this is to make sure that, while we are promoting quality care, that we do it in a way that is most cost-effective for the taxpayer. Most of

the changes that we do in the Medicare space are focused on those two things, and trying to balance those two.

Mr. BUSCHON. OK. And has HHS or CMS looked into the administrative costs the new systems will have on doctors and CMS? The reason I ask is, in my practice—I will give you some examples of how this actually will work——

Secretary BURWELL. Yes.

Mr. BUSCHON [continuing]. Or won't work if you do it. We would bill a global payment, for everything, including follow-up visits.

Secretary BURWELL. Yes.

Mr. BUSCHON. And now doctors will be billing for the surgery, every hospital round that they make, every follow-up appointment, all separately, let me finish. And not only would the medical practice have to pay employees to submit what I consider excessive claims, but then CMS will have to process each claim. And how can that not cost CMS more money, not less? That is my first question.

Secretary BURWELL. With regard to the global payment issue, and one of the things—Dr. Patrick Conway—we try and have physicians who are practicing at the table as we have these conversations. Want to understand the point that you are making and how we believe—I want to look into this one, in terms of a specific answer to your——

Mr. BUSCHON. It will be a dramatic increase. Let me tell you why. If I did an open heart surgery on a patient, I would see them in the ICU anywhere from 3 to 5 days every day, and then probably two to three follow-up appointments. That is all under a global.

Secretary BURWELL. Yes.

Mr. BUSCHON. And so now that—those numbers will be submitted as individual bills. From a surgeon's perspective, I see this as—and I think seniors should be paying attention to these comments. This is going to be a dramatic pay cut for surgeons across this country, and that is—in my view, that is where any potential savings will be coming from. So as you look at this, you should really—I would encourage you to pay attention to that, because what will happen is there is going to have to be re-evaluation of every code, re-evaluation of every follow-up appointment. You are going to have to discern whether there is duplicate billing. For example, if I see a patient post-op in the ICU, and a critical care physician is also seeing my patient that day, who gets paid, who doesn't get paid? There will be increased denials. My point is this. Global payments were put in place to save money——

Secretary BURWELL. Yes.

Mr. BUSCHON [continuing]. Administratively, and also simplify, and I think improve, quality of health care. And I think going backwards away from that is regressing backwards. Yes, it will save money. This will save money by dramatically cutting provider reimbursement. And if that is the intent, that is unfortunate, because what will also result is access issues for seniors for health care services, and, I would argue, less quality health care.

And so, most of these bundles are re-examined every few years by—and so the argument that overbilling is occurring, if that were to be true, then these bundles are looked at every couple years and re-evaluated, so, on that subject, I would encourage you to take a

really hard look at global payments. They save money, and they don't cost money. The savings will be on the backs of seniors' access to health care, and quality, in my opinion.

The other thing is the President's budget would seek to save 20.9 billion in savings over the next 10 years by strengthening the IPAD Board, a board of unelected members selected by the President to cut—in my view, to cut Medicare payments to providers. I understand the President has not yet nominated anyone to sit on the IPAD Board, so it could not recommend Medicare cuts this year. So in what year under the President's budget will IPAD begin to make recommendations on Medicare costs?

Secretary BURWELL. In the current President's budget, IPAD would not kick in until 2019.

Mr. BUSCHON. 2019?

Secretary BURWELL. That is right.

Mr. BUSCHON. OK. Thank you. Thank you, Mr. Chairman. I yield back.

Mr. PITTS. Chair thanks the gentleman. Now recognize the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. COLLINS. Thank you, Mr. Chairman, and thank you, Secretary, for being here today. I am from Western New York, which is a very rural community. We have one of the highest enrollments for Medicare Advantage. I know prior to the Affordable Care Act I would say that without a doubt one of the bright spots in the delivery of health care in the United States was Medicare Advantage. Dealt with the donut hole. It was a lot of comfort for the seniors to be able to go in, much like we do with HMOs—a great program. And yet, as was brought out earlier, and I want to get into this, it seems as though the President, and the Administration, and HHS views Medicare Advantage with some level of disdain, in that it is the piece that keeps getting cut.

And as I look through some of the data, and I am kind of a data-driven guy, the interesting thing I found about Medicare Advantage, there are over seven million enrollees, represents almost 30 percent of the Medicare population, which would indicate it works. Number two, when you look at who uses it, lower income beneficiaries have a higher enrollment in Medicare Advantage than do wealthier individuals, which means it is serving best some of the lower income populations. We have also seen that, when I look at the rural plans, again, in rural America, which I represent, a higher percentage of folks from rural America are using it.

So I am just asking the question, as—and the interesting thing too, the—that information we got today was from AHIP. They said the current 0.9 percent, the 0.9 percent cut that is coming now in the subsidy to insurance companies for Medicare Advantage, is going to add another $20 a month to beneficiaries, either in higher premiums, or reduced benefits. So could you speak to just the opinion of older Americans on Medicare, that they are being used as the funding source for the expansion in Medicaid, and all of those increased costs on the back of our seniors, who have depended on this great program for all these years? A frustration level exists within that population.

Secretary BURWELL. Appreciate that, and as I responded to your colleague with regard to the issues of Medicare Advantage, I would

say we support the program, believe the program is a good program, but also believe that our responsibility, where we think there are things that are happening, whether that is up-coding or other things, that we try and take care of that.

The changes that we have done, we have tried to transition those changes. We have tried to do those changes slowly so that we watch and monitor. We have seen an increase in the number of people in Medicare Advantage. We have seen premiums hold steady. We have seen an increase in quality. So the negative impacts that were articulated at the beginning of those proposals, we have not seen. We want to continue to monitor and make sure that we don't see some of the negative impacts that you were talking about. We value the program. We think the changes—they have been recommended by MedPAC and others.

We understand the concerns, but trying to operate in a world—and with regard to the other issue that you mentioned, I would just say across the board—and whether it is the issue that your colleague just mentioned, with regard to—or the $780 million we do in discretionary cuts, we try to spread these things across the entire parts of our budget.

Mr. COLLINS. But are you aware that there now over 200 counties in the United States that don't have a Medicare Advantage plan at all to offer their seniors as a direct result of the cuts you have made? So when you say it hasn't had this impact, there are seniors in over 200 counties in the United States that can't even buy the coverage.

Secretary BURWELL. So 99 percent of the Nation has coverage, in terms of the beneficiaries' accessibility.

Mr. COLLINS. But yet the number who don't has increased, from 55 counties before the ACA to over 200 today. So there is a direct impact. I mean, the data is the data. You can't make it go away.

Secretary BURWELL. With regard to those numbers, as I said, I have the number of the current coverage, and would want to understand the change over the——

Mr. COLLINS. Yes. What I am trying to point out is it has had—the reason you are looking for this funding is to pay for the expansion of Medicaid. I mean, whether it is the health insurance tax, or the individual mandate, or whatever, the big cost driver has been this huge expansion in Medicaid, would be my observation.

Secretary BURWELL. What I would observe is some of the comments that have been stated about the question of overall entitlements and the growth, we have a bulge of population. We have a large group of people who are elderly in Medicare. The Medicare costs, even though we have controlled per capita costs for Medicare over the period of what we are seeing, because more people from the baby boom are retiring and older, that is an issue that we, as a Nation, are going to have to look at and deal with. Medicare costs are going to continue to increase because of volume, even if we can control per capita cost.

And so with regard to the questions of what will be costing the Nation money over periods of time, the issue of Medicare is one on a—because we are going to have the baby boom, and the echo come through, we are going to continue to have to make good on the

commitments we have made. And that will cost us, because even if you control it per capita, volume is greater.

Mr. COLLINS. Well, thank you for the answer. My time has expired. Yield back.

Mr. PITTS. Chair recognize the gentleman from New Mexico, Mr. Lujan, 5 minutes for questions.

Mr. LUJAN. Thank you very much, Mr. Chairman, and I would yield to our Ranking Member, Mr. Green, for a quick response as well.

Mr. GREEN. Thank you, Mr. Chairman. I want to respond to my colleague from New York. I have not had any of my seniors question the expansion of Medicaid, based on what is happening with Medicare. The Affordable Care Act was totally paid for, and, in fact, Medicare was improved under the Affordable Care Act. And, Madam Secretary, this is the first I have heard that seniors are complaining that the Medicaid expansion is being paid out of Medicare. That is just not, in fact, that I hear about. Did you have any information on that?

Secretary BURWELL. That is the first that I have heard that anyone felt that that was an issue, with regard to the Federal budget, because I assume that is what they are referring to.

Mr. COLLINS. If the gentleman would yield one minute——

Mr. LUJAN. Thank you. Reclaiming my time, thank you, Madam Secretary, for your testimony today. I want to reiterate what many of my colleagues have said, that we must repeal the SGR, but not on the backs of seniors, and that a strong CHIP extension must be included with the SGR in March as well. Also that the Affordable Care Act is working, despite an attempt of over 50 Republican repeal attempts. The ACA has had a positive impact on New Mexico, in my home state. In my home district, 25,000 people now have quality, affordable health coverage because of the Affordable Care Act that didn't before, and overall the numbers of uninsured has declined by 17 percent.

With the law now full in effect, Americans can never be discriminated against because of pre-existing conditions. Women can never be charged more for coverage because of their gender, and Americans will never be sold health insurance policies that disappear when they need coverage most, when they hit those lifetime caps, and suddenly coverage goes away. I think that it is time that we come together and work to strengthen the law, and stop playing political games that will strip millions of Americans of the health coverage they depend on. As my father would say, enough is enough.

Madam Secretary, in your opinion, has the Affordable Care Act had a positive impact on places around the country, including my home state of New Mexico?

Secretary BURWELL. Yes, and I think it has in three areas, affordability, access, and quality. With regard to the issues of quality, you touched upon a number of the areas where I believe there is been an improvement in quality, and those are the fact that people can have their children covered up to 26, the quality that you don't—if you have a pre-existing condition, you can't be kept out, or thrown off of your health care. If you take your child in for their wellness visit, there isn't co-insurance. You don't have to pay, in terms of that preventative care. So increases in quality. We have

also seen increases in quality through partnerships we are doing with physicians, and we have seen a 17 percent reduction in harms. Those are things like infections and falls in hospitals. That is also about saving lives, but it is also about money.

With regard to the issue of affordability, and the progress that we have made on affordability, while we can all still continue to make more, we have in that space, and what we have seen is that, in the years 2011, '12, and '13, we have seen a record in terms of per capita health care cost growth. It is one of the lowest that we have seen on record, and we have seen that. That is in the broader marketplace.

With regard to the individual market, what we have seen is that people—the vast majority, over 8 in 10 folks in the marketplace can find coverage using a subsidy that is $100 or less in a month. That is affordability in that marketplace. With regard to affordability and the taxpayer, CBO estimates pre the Affordable Care Act would have estimated that spending in Medicare would have been $116 billion greater. Affordability for the taxpayer.

Lastly, access. The question of access, and the fact that 11.4 million people have come through the marketplace this time, but let us even use last year's number, where we saw a 10 million person drop in the number of uninsured. So, against the three fundamental measures, that is how I would think about it.

Mr. LUJAN. I appreciate that, Madam Secretary. Thank you for your response there, and I do want to raise an issue that has great concern to my constituents and to myself back in New Mexico. It has now been over 18 months since the State of New Mexico claimed credible allegations of fraud, or their allegations of fraud, against 15 behavioral health providers, resulting in the eventual closure or replacement by five Arizona behavioral health providers. This transition and turmoil has raised significant concerns across access to care, especially in light of recent reports that the new providers are financially unstable. In fact, one provider is already pulling out of New Mexico.

The recently elected New Mexico Attorney General has also released the audit that led to the suspension, and it shows a lack of underlying basis for many of the allegations of fraud. My staff has had several meetings with CMS, and I am very concerned that we are not making progress. When payment suspensions are put into place, what CMS do to ensure states are acting in good faith, and what is CMS doing to stop the reoccurrence of this happening, both in New Mexico and other states, and can I have your commitment that we can work together on this particular issue and met with the delegation?

Secretary BURWELL. Do want to work with you on this issue. Know it is one of concern, in terms of making sure that people have access to those benefits.

Mr. LUJAN. I appreciate that. Thank you very much. I yield back the balance of my time.

Mr. PITTS. Thank the gentleman. Now recognize the gentlelady from North Carolina, Ms. Ellmers, 5 minutes for——

Mrs. ELLMERS. Thank you. And thank you, Madam Secretary, for being with us today. I do have three different questions to ask you about, but I do want to address the issue of Medicare, and our sen-

iors who are concerned. It is my recollection, and I am just going back to history, that over $700 billion was taken out of Medicare in order to pay for Obamacare. About 300 billion of that was Medicare Advantage. So to the question of whether or not our seniors are concerned about that, I say yes, they are concerned about that, and they want to make sure that they will be able to continue to get the care they deserve.

I want to start off by talking about Medicare reimbursement in relation to the two percent sequester cuts that were put in place a number of years ago, which dramatically affected our chemotherapy drugs and Part B drugs. As you know, this has affected our industry. Back on January 14 of 2013, Office of Management and Budget put out a letter asking Federal agencies to, "use any available flexibility to reduce operational risks, and minimize impacts of the agency's core mission in service of the American people."

Some adverse things happened as a result. of the two percent cut over 16 months, after CMS started applying the two percent cut, We basically ended up with 25 community oncology clinics closing, one of which was a very large clinic in my own district. Seventy five others merged with hospitals. CMS's own numbers show that it costs $6,500 more per year per patient on oncology services if they are part of the hospital system, versus the clinic setting, or outpatient setting, which is about $650 more out of pocket.

Why hasn't CMS taken the recommendation of OMB and addressed that situation?

Secretary BURWELL. Congresswomen, we agree with you about sequester, and in this budget, we fully get rid of sequester, both on the mandatory side, and on the discretionary side. We believe there are other choices that are better choices, and so agree with you, this is not an approach—when you use an approach like this——

Mrs. ELLMERS. Yes.

Secretary BURWELL [continuing]. You end up doing things like the types of things you are talking about. And so what we want to do is fully replace it, and that is what our budget does. We are willing to make other choices, in terms of how we get those savings.

Mrs. ELLMERS. Thank you. And I will go on to a very important question, having to do, essentially, with our tobacco products. My question for you is, do you agree with Mitch Zeller, Director of FDA Center for Tobacco Products, that if the smokers, and I am quoting him, "who are otherwise unable or unwilling to quit were to completely switch to smokeless tobacco products, it would be good for the public health." Do you agree with this statement?

Secretary BURWELL. I would have to understand the context in which he made that statement. With regard to the question, I think, you know, we want to promote the public health. We want to——

Mrs. ELLMERS. Yes.

Secretary BURWELL [continuing]. Make sure we are doing the right research to understand that, and put in place the right guidelines and regulations to do it.

Mrs. ELLMERS. Well, thank you. I do want to add that there are no government Web sites that help promote or address this issue,

including CDC, FDA, NIH. It would be helpful for the public to understand that there are the non-tobacco products available, and this is an approach we need to make. I would welcome the ability to continue to work with you, and your office, on any way that we can better help to get the information out, and address the needs from a scientific basis, using the scientific research that is out there.

I do want to switch gears to our vaccines and to BARDA. Right now BARDA maintains a stockpile of roughly $1.7 billion worth of pandemic influenza vaccine. This year's budget, I believe, is about $20 million in order to take care of that stockpile and maintain it. Does the 2016 budget increase that amount, and how does BARDA plan on dealing with those issues, especially when our situation is very timely?

Secretary BURWELL. Across the board our budget has worked to do a couple of things with regard to the preparedness, making sure that that vaccine stockpile, and that the issues that BARDA handles——

Mrs. ELLMERS. Yes.

Secretary BURWELL [continuing]. Which are making sure that what we have on hand in stockpile, and that we have the ability to work with manufacturers to bring new products online, where that is appropriate——

Mrs. ELLMERS. Yes.

Secretary BURWELL [continuing]. For different types of issues that we as a Nation may face, either man-made or otherwise. But we also have paired that with things in our budget which are about the preparedness in our communities——

Mrs. ELLMERS. Yes.

Secretary BURWELL [continuing]. And we have seen that front and center, certainly, in our time period. We are implementing the dollars we appreciate from Congress as part of that, in terms of Ebola, but also broader preparedness——

Mrs. ELLMERS. Yes.

Secretary BURWELL [continuing]. Where we have been given that authority by the Congress.

Mrs. ELLMERS. Thank you, Secretary Burwell, for being here today. I truly appreciate your input. Thank you.

Secretary BURWELL. Thank you.

Mr. PITTS. Chair thanks the gentlelady. That concludes the questions of the members who are present. I am sure we will have lots of follow up and written questions from some of the members, so we will get those to you promptly. We ask that you please respond to the questions promptly. I remind members that they have 10 business days to submit questions for the record, and that means they should submit their questions by the close of business on Thursday, March the 12th.

Thank you very much, Madam Secretary, for your attendance today and your answers. Without objection, subcommittee is adjourned.

[Whereupon, at 12:55 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

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MEMORANDUM January 7, 2015

To: House Committee on Energy and Commerce
[redacted]

From: Andrew L. Nolan, Legislative Attorney, 7-0602
C. Stephen Redhead, Specialist in Health Policy, 7-2261

Subject: **Scope of the Legal Authority for the Office of the National Coordinator for Health Information Technology**

Pursuant to your request, this memorandum analyzes the scope of the current legal authority for the Office of the National Coordinator for Health Information Technology (ONC) within the Department of Health and Human Service (HHS). Specifically, this memorandum examines whether the ONC currently possesses the authority to create a Health IT Safety Center[1] ("Health IT Safety Center" or "Safety Center") as referenced in an April 2014 report entitled "FDASIA Health IT Report: Proposed Strategy and Recommendations for a Risk-Based Framework" ("April 2014 Report") jointly issued by the Food and Drug Administration (FDA), the Federal Communications Commission (FCC), and the ONC.[2] This memorandum begins by describing the history of ONC, the office's legal authority with respect to the use and exchange of electronic health information within the United States, and the proposed Health IT Safety Center. The memorandum concludes by analyzing whether the agency is authorized to create the Safety Center as described in the April 2014 Report and elsewhere.

ONC and its Current Legal Authority

ONC was formally[3] established in section 13101 of the Health Information Technology for Economic and Clinical Health (HITECH) Act within the American Recovery and Reinvestment Act of 2009 (ARRA).[4] The purpose of the agency generally is to promote "the development of a nationwide health information technology infrastructure that allows for the electronic use and exchange of information . . . ."[5] The

[1] This memorandum does not examine whether ONC possesses the authority to take exploratory action respecting the Health IT Safety Center, such as entering into contracts or issuing grants developing the concept of the Safety Center.

[2] *See* FDA, FCC & ONC, "FDASIA Health IT Report: Proposed Strategy and Recommendations for a Risk-Based Framework," April 2014, *available at* http://www.healthit.gov/sites/default/files/fdasiahealthitreport_final.pdf (herein "FDASIA Report").

[3] ONC was originally created by Executive Order 13335 on April 27, 2004, an order naming ONC as the "primary advisor" for HHS for health information technology. *See* Exec. Order No. 13335, 69 FED REG. 24059, 59 (April 30, 2004) ("The Secretary of Health and Human Services (Secretary) shall establish within the Office of the Secretary the position of National Health Information Technology Coordinator.").

[4] *See* Pub. L. 111-5, 123 Stat. 115, 230, *codified at* 42 U.S.C. § 300jj-11(a).

[5] *See* 42 U.S.C. § 300jj-11(b). The HITECH Act specifies several more broad-based concerns and purposes for ONC, including promoting the security of each patient's health information, *see* 42 U.S.C. § 300jj-11(b)(1), improving the quality of health care (continued...)

HITECH Act authorizes the National Coordinator—the "head of [ONC]"[6] — to conduct several statutorily assigned tasks.[7]

First, the National Coordinator is authorized to "review and determine" whether to "endorse" certain "standard[s], implementation specification[s], and certification criteri[a]" regarding the exchange and use of health information as recommended by the Health Information Technology (HIT) Standards Committee.[8] The HIT Standards Committee is established under section 3003 of the Public Health Service Act (PHSA) and is charged with making recommendations regarding "standards implementation specification, and certification criteria for the electronic exchange and use of health information" to the National Coordinator.[9] In turn, under section 3004 of the PHSA, within 90 days of receiving "standards, implementation specifications, or certification criteria" that the National Coordinator has endorsed, the Secretary of HHS, in consultation with other relevant agencies, must determine whether or not to propose adoption of the endorsed policy.[10] If an endorsed policy is formally proposed for adoption by the Secretary, the proposal is then subject to the general requirements for rulemaking under the Administrative Procedure Act, including notice and comment rulemaking.[11]

The import of the phrase "standards, implementation specifications, and certification criteria" is established elsewhere in the HITECH Act. Specifically, in section 3001(c)(5) of the PHSA, the National Coordinator is authorized to "keep or recognize a program or programs for the voluntary certification of [HIT] as being in compliance with applicable certification criteria . . . ."[12] The HITECH Act further defines "certification criteria" as the "criteria" that "establish[es]" that HIT "meets" "standards and implementation specifications."[13] HIT is a term of art broadly defined by the Act to mean "hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance access, or exchange of health information."[14] In other words, the HITECH Act gives ONC relatively broad authority to promote the use and exchange of electronic information through a certification program that helps ensure that various health information technologies comply with HIT standards and implementation specification promulgated by HHS.

In practice, ONC's certification criteria have been targeted at electronic health record (EHR) technology,[15] a subcategory of HIT that is focused on electronic records of health-related information about an

(...continued)

through the exchange and use of health information, *id.* (b)(2), (6)-(9), (11), reducing health care costs, *id.* (b)(3), and improving the informed health care decisions of the public, *see id.* (b)(4)-(5).

[6] *See* 42 U.S.C. § 300jj(11).

[7] *See id.* § 300jj-11(c).

[8] *Id.* (c)(1). The National Coordinator has 45 days to act on a recommendation. *Id.* (c)(1)(B).

[9] *See* 42 U.S.C. § 300jj-13(a). The HIT Standards Committee's work is a product of the work of another committee established under section 3002 of the PHSA, the HIT Policy Committee. *See* 42 U.S.C. §300jj-14(a). The HIT Policy Committee is generally tasked with making recommendations respecting a "policy framework for the development and adoption of a nationwide health information technology infrastructure that permits the electronic exchange and use of health information . . .", with the specific duty of having to identify the "areas in which standards, implementation specifications, and certification criteria are needed . . . ." *See* 42 U.S.C. §300jj-12(b).

[10] *See* 42 U.S.C. § 300jj-14(a).

[11] *Id.* (a)(2)(A) (citing 5 U.S.C. § 553).

[12] *See* 42 U.S.C. § 300jj-11(c)(5)

[13] *See id.* (c)(5)(B).

[14] *See id.* § 300jj(5).

[15] *See, e.g.*, 79 FED. REG. 52,910 (Sept. 4, 2014)

individual that includes "patient demographic and clinical health information" and has the "capacity . . . to provide clinical decision support, . . . to support physician order entry, . . . to capture and query information relevant to health care quality, . . . and . . . to exchange electronic health information with , and integrate such information from other sources."[16] Specifically, ONC has confined its regulatory activity to supporting the Medicare and Medicaid EHR incentive programs established by the HITECH Act, which provide an eligible health care provider, such as a physician or an acute-care hospital, [17] with certain "incentive payments" if the provider can demonstrate meaningful use of EHR technology that is certified "pursuant to [PHSA] section 3001(c)(5) . . . as meeting standards adopted under section 3004" by HHS.[18]

Importantly, an entity's failure to use EHR technology that does not comply with the "certification criteria, standards, and implementation specifications" enacted pursuant to the HITECH Act generally results in one consequence: the inability for that entity to obtain benefits through the incentives established under the ARRA. Put another way, ONC's "certification criteria, standards, and implementation specifications" do *not* broadly create rules of law with civil or criminal penalties that could result from a violation of an underlying rule.[19] Likewise, pursuant to section 3006(a)(2) of the PHSA, the HITECH Act generally does not provide any federal agency, including the ONC, with the authority "to require a private entity to comply with . . . a standard or implementation specification."[20]

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[16] *See* 42 U.S.C. § 300jj(1)&(13).

[17] Eligible entities includes eligible professionals, hospitals, and Medicare Advantage organizations. *See* Pub. L. 111-5, 123 Stat. 115, 467, §§ 4101-4102, 4201.

[18] *See, e.g., id.* § 4101 (codified at 42 U.S.C. § 1395w-4(o)(1)(A)(ii)) (Medicare); *id.* § 4201 (codified at 42 U.S.C. § 1396b(t)(5)(D)) (Medicaid)). The ARRA also authorized downward payment adjustments under Medicare, beginning in 2015, for eligible entities that are not meaningful users of certified EHR technology. *See id.* § 4101 (codified at 42 U.S.C. § 1395w-4(a)(7)). In addition to the Medicare and Medicaid incentive programs, HIT certification is the lynchpin for other incentive programs established under subtitle B of the HITECH Act. For example, in order to "assist health care providers to adopt, implement, and effectively use" certified EHR technology, subtitle B of the HITECH Act requires that the Secretary of HHS invest in infrastructure "necessary to allow for and promote" the effective exchange and use of health information, including the "development and adoption" of EHR technology. *See* 42 U.S.C. § 300jj-31(a); *see also id.* § 300jj-31(d) (requiring that the Secretary ensure that funds expended under section 3011 be devoted to the acquisition of HIT that meet "applicable standards adopted under section 3004."). Moreover, the Act also requires the Secretary to establish a "Health Information Technology Research Center" and "Health Information Technology Regional Extension Centers" that collectively provide "technical assistance" and develop and recognize "best practices" in order promote the effective exchange of electronic information and the use of information that is in "compliance with" HIT standards, specifications, and certification criteria adopted by the Secretary. *See id.* § 300jj-31(b)-(c). The HITECH Act also authorizes the Secretary of HHS, through ONC, to award grants of money geared toward promoting compliance with ONC's certified criteria. *See, e.g., id.* § 300jj-33 (authorizing the awarding of planning and implementation grants to "State or qualified State-designated entities" to "promote" HIT); *id.* § 300jj-34 (authorizing the awarding of competitive grants to states and Indian tribes for the development of loan programs to facilitate the widespread adoption of certified EHR technology); *id.* § 300jj-35 (authorizing the awarding of grants to "carry out demonstration projects to develop academic curricula integrating certified EHR technology in the clinical education of health professionals."). Importantly, the appropriations for the incentive programs established under subtitle B of the HITECH Act were limited to fiscal years 2009 through 2013. *See id.* § 300jj-38. In contrast, incentive payments under the ARRA's Medicare and Medicaid EHR incentive program can occur through the year 2016. *See* Pub. L. 111-5, 123 Stat. 115, 467-68, § 4101.

[19] *See* 42 U.S.C. § 300jj-16(a)(1) ("[N]othing in such Act or in the amendments made by such Act shall be construed . . . to require a private entity to adopt or comply with a standard or implementation specification adopted under section 3004").

[20] *Id.* § 300jj-16(a)(2). There is a limited exception to the rule of construction outlined in section 3006 PHSA, in that pursuant to section 13112 of the HITECH Act, an agency must require in "contracts or agreements with health care providers, health plans, or health insurance insurers" that the entity contracting with the federal government "utilize, where available, [HIT] systems and products that meet the standards and implementation specifications adopted under section 3004 of the [PHSA] . . . ." *See* Pub. L. 111-5, 123 Stat. 115, 243, § 13112. While violating a provision of a federal contract requiring adherence to HIT standards and implementation mechanisms could result in collateral consequences–such as the payment of damages resulting from a breach of contract—the resulting authority provided to the federal government is limited in scope. Section 3006(b) of the PHSA states that nothing in the HITECH Act "shall be construed to require that a private entity that enters into a contract with the Federal (continued...)

Beyond endorsing "certification criteria, standards, and implementation specifications" to promote the use and exchange of electronic health information, ONC has a number of more limited ministerial duties under the HITECH Act. For example, the National Coordinator is authorized to "coordinate health information technology policy and programs" of HHS with "those of other relevant executive agencies" in order to "avoid[] duplication of efforts."[21] In addition, ONC is charged with updating and publishing the "Federal Health IT Strategic Plan,"[22] a policy document that describes the federal government's strategy—including "specific objectives, milestones, and metrics"[23]—to improve health and health care through the use of health information and technology.[24] Moreover, the National Coordinator is obligated to submit five different reports: (1) assessing the current funding and legal authority for the ONC; (2) identifying "lessons learned" from private and public health care systems that use health information technology; (3) assessing the impact of health information technology on "communities with health disparities and in areas with a high proportion of individuals who are uninsured, underinsured, and medically underserved;" (4) evaluating the costs and benefits of the electronic use and exchange of health information; and (5) estimating and publishing the "resources required annually to reach the goal of utilization of an electronic health record for each person in the United States by 2014 . . . ."[25] The ONC is also authorized to provide financial assistance to certain "consumer advocacy and not-for-profit entities that work in the public interest" in order to "defray the cost to such groups and entities" so that they can participate under the National Technology Transfer Act of 1995.[26] ONC must also "maintain and frequently update an Internet website" containing information on the work of the ONC, including any reports or recommendations the agency issues.[27] Finally, section 3007 of the PHSA allows the ONC to "support the development and routine updating" of EHR technology and to "make available" certified EHR technology to the public.[28]

Health IT Safety Center Proposal

Acting pursuant to section 618 of the Food and Drug Administration Safety and Innovation Act (FDASIA),[29] in April of 2014, FDA, FCC, and ONC jointly published a report, which, in relevant part,

(...continued)

Government apply or use the standards and implementation specifications . . . with respect to activities *not* related to the contract. 42 U.S.C. § 300jj-16. It should be noted that the HITECH Act authorizes the National Coordinator to "establish a governance mechanism for the nationwide health information network," *see id.*§ 300jj-11(c)(8), but nowhere does the statute define what a "governance mechanism" entails.

[21] *See* 42 U.S.C. § 300jj-11(c)(2).

[22] *Id.* (c)(3).

[23] *Id.*

[24] *See* ONC, *Federal Health IT Strategic Plan Progress Report*, July 19, 2013, *available at*, http://www.healthit.gov/policy-researchers-implementers/federal-health-it-strategic-plan-progress-report. The HITECH Act outlines some specific subjects that the Federal Health IT Strategic Plan must discuss, including the "electronic exchange and use of health information and the enterprise integration of such information." *See* 42 U.S.C. § 300jj-11(c)(3) (A)(i)-(viiI). In addition, the PHSA mandates that the National Coordinator "review Federal health information technology investments" to ensure that "Federal health information technology programs" are compliant with the objectives of the strategic plan. *See id.* (c)(1)(C).

[25] *Id.* (c)(6)(A)-(E).

[26] *Id.* (c)(7). The National Technology Transfer Act of 1995 mandates that all federal agencies use technology standards developed and adopted by voluntary consensus standard bodies. *See* 15 U.S.C. § 272 note.

[27] *See* 42 U.S.C. § 300jj-11(c)(4).

[28] *See* 42 U.S.C. § 300jj-17(a)-(b). The ONC is authorized to charge nominal fees for the adoption of technology made available under section 3007 of the PHSA, *see id.* § 300jj-17(c), but section 3007 cannot be construed as an affirmative source of authority to require that a private or governmental entity must adopt or use certified EHR technology, *see id.* § 300jj-17(d).

[29] *See* Pub. L. 112-144, § 618(a).

proposed the "creation of a Health IT Safety Center."[30] The Health IT Safety Center proposal, as described in the report, would be a "public-private entity" "created by ONC" that would "convene stakeholders in order to focus on activities that promote" HIT.[31] The "ultimate goal" for the Safety Center is to "creat[e]" a "learning system" that "avoids regulatory duplication and leverages and complements existing and ongoing efforts."[32] While the FDASIA Report is short on specifics as to the exact role of the Health IT Safety Center, the Report does note that the Safety Center "will require a strong governance mechanism and involvement by participants in programs and activities" that (1) "[e]stablish a broad and engaged stakeholder membership and leadership base;" (2) "[f]ocus on high-value issues" respecting HIT; (3) analyze the "best available data and evidence" respecting HIT safety; (4) "create or inform [HIT] priority goals and measures that align with broader patient safety goals and initiatives;" and (5) "[p]rovide education on [HIT] safety . . . ."[33]

In May of 2014, the Director of the Office of Policy and Planning for ONC, in a presentation (herein May 2014 Presentation) on the April 2014 Report, further elaborated on the Health IT Safety Center proposal.[34] In the Director's May 2014 Presentation, the Safety Center was described as a "public-private entity" that would "serve as a trusted convener of [HIT] stakeholders and identify the governance structures and functions needed for the creation of a sustainable, integrated [HIT] learning."[35] However, the precise contours of the Health IT Safety Center remained undefined, as the presentation actively asked for "input" as to the Safety Center's "governance structure" and "functions."[36]

In August of 2014, following a meeting one month earlier,[37] the HIT Policy Committee provided the National Coordinator with a host of recommendations for the Health IT Safety Center, broadly suggesting that the Center provide a "non-regulatory role and focus on recommendations for [HIT] policy and standards," with an emphasis on "learning, not enforcement."[38] In this vein, the Policy Committee recommended that the "key functions" of the Safety Center could include serving as a "Clearinghouse for HIT safety-related theories and ideas for best practices."[39] The Policy Committee also suggested that the Safety Center should "review . . . evidence" from stakeholders and "partner with other organizations . . . that conduct investigations" regarding HIT adverse events.[40] The August 2014 recommendations from the Policy Committee envisioned the Health IT Safety Center "start[ing] small in scope and gradually grow[ing]."[41]

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[30] FDASIA Report at 4.

[31] *Id.*

[32] *Id.* at 14.

[33] *Id.* at 14-15.

[34] *See* Jodi G. Daniel, *FDASIA Health IT Report,* May 6, 2014, *available at* http://www.healthit.gov/facas/FACAS/sites/faca/files/HITPC_FDASIA_Overview_2014-05-06.pptx (herein May 2014 Presentation).

[35] *Id.* at 15-16.

[36] *Id.* at 17.

[37] *See* Health IT Policy Committee, *Safety Task Force*, July 7, 2014, *available at* http://www.healthit.gov/facas/sites/faca/files/HITPC_STF_%20Report_Recommendations_2014-07-08.pdf

[38] *See* Paul Tang, *Letter to National Coordinator Karen DeSalvo,* August 4, 2014, at pg. 2, *available at* http://www.healthit.gov/facas/sites/faca/files/STF__Safety_Center_Transmittal_2014-08-05.pdf.

[39] *Id.*

[40] *Id.*

[41] *Id.* at 3.

In September of 2014, ONC issued a report entitled "ONC Health IT Safety Program –Progress on Health IT Patient Safety Action and Surveillance Plan."[42] In the September report, ONC disclosed that it had solicited offers for developing a road map for the Safety Center and that the awarding of such a contract would occur by the end of September.[43] News reports from early October indicated that ONC awarded a contract to RTI International in order to develop a road map for a potential Health IT Safety Center.[44] In turn, RTI International released a document entitled "Health IT Safety Center Road Map Task Force ("RTI Road Map")," which includes a "summary of operational considerations for a potential Health IT Safety Center[]."[45] In particular, in the RTI Roadmap, the contractor lists seven different "potential core activities" for the Health IT Safety Center, including "provid[ing] educational programs about research and activities;" "analyz[ing] evidence on HIT safety and safety tool/interventions" and producing written reports; and identifying HIT safety research "goals, priorities and related measures."[46] RTI International's summary also includes several "boundaries on the scope" of the Health IT Safety Center's activities, including that the Safety Center will not "engage in direct investigation or surveillance," perform "direct data collection," or exercise regulatory authority.[47] The RTI Road Map envisions "developing, vetting, finalizing, and submitting" a final Road Map on the Safety Center to ONC in the spring of 2015.[48]

ONC's Authority to Create a Health IT Safety Center

The determination of whether ONC has the authority to create the Health IT Safety Center, as with any question respecting the scope of an administrative agency's authority to undertake a certain action, ultimately turns on the specifics of the action the agency is considering coupled with the "nature and scope of the authority granted by Congress to the agency."[49] Unfortunately, it is very difficult to ascertain the precise contours of ONC's proposed Safety Center because of both the somewhat cryptic nature in which the Health IT Safety Center has been described thus far by the agency and because of the tentative nature of the proposal.

To date, the ONC's descriptions and discussion of the proposed Health IT Safety Center has at times been vague and imprecise, even hinting at the possibility that the Center would have some type of regulatory role, such as having the power to establish governing rules for the HIT industry.[50] On the other hand,

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[42] *See* ONC, ONC Health IT Safety Program –Progress on Health IT Patient Safety Action and Surveillance Plan, Sept. 9, 2014, *available at* http://www.healthit.gov/sites/default/files/ONC_HIT_SafetyProgramReport_9-9-14_.pdf.

[43] *Id.* at 5.

[44] *See* Ashley Gold, *ONC laying groundwork for health IT safety center*, POLITICO, Oct. 9, 2014, *available at* http://www.politico.com/morningehealth/1014/morningehealth15622.html.

[45] *See* RTI Int'l, *Health IT Safety Center Road Map Task Force, available at* http://www.healthitsafety.org/uploads/4/3/6/4/43647387/health_it_safety_center_scope_final.pdf (hereinafter "RTI Road Map").

[46] *See id.* at 2. Other goals included: (1) promoting opportunities for engagement in HIT related safety activities and programs in the public sector; (2) fostering health IT safety research and development in the private sector and by government; (3) encouraging stakeholders to measure, evaluate, and share progress related to identified goals respecting HIT; and (4) provide a forum for private-sector stakeholders and Federal Government representatives to dialogue and work together. *Id.*

[47] *See id.*at 3-4.

[48] *Id.* at 5.

[49] *See* La. Public Serv. Comm'n v. FCC, 476 U.S. 355, 374 (1986).

[50] For example, the April 2014 Report envisions the Health IT Safety Center as "creat[ing] . . .[a] system that avoids regulatory duplication" and "creat[ing] . . . measures that align with broader patient safety goals and initiatives," a role that presumably would have the Center promulgate and repeal rules respecting HIT to create a coherent regulatory regime. *See* FDASIA Report at 14-15. More particularly, the April 2014 Report, *see id.* at 14, the May 2014 Presentation, *see* May 2014 Presentation at 5 ("Implement IOM Health IT safety recommendations to create a 'learning environment' . . . Cross-agency group should establish governance of Health IT safety."), and the August recommendations from the Policy Committee, *see* Paul Tang, *Letter to*

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other statements by ONC and RTI International explicitly preclude the Safety Center from having a regulatory function, and instead envision the Health IT Safety Center as an informal clearinghouse where public and private entities can broadly share ideas on HIT.[51]

While the seemingly conflicting and vague language respecting the role envisioned for the Health IT Safety Center may ultimately reflect the fact that the Safety Center is still largely undefined,[52] the plain language of the HITECH Act appears to foreclose any regulatory role for the Safety Center. After all, the HITECH Act specifically limits the authority provided under the Act, in that the statute cannot be construed to "require a private entity to adopt or comply with a standard" proposed by ONC and promulgated by HHS under section 3004 of the PHSA.[53] Likewise, under section 3006(a)(2) of the PHSA, the HITECH Act generally does not provide any federal agency, including the ONC, with the authority "to require a private entity to comply with . . . a standard or implementation specification."[54] As noted above, ONC's statutory role is largely centered on proposing "standards, implementation specifications, and certification criteria" that form the basis for several incentive programs established under the ARRA to encourage, rather than require, entities to adopt certified HIT.[55]

Putting to the side the possibility that the proposed Safety Center would have a robust regulatory role, the question remains as to whether ONC can establish a Health IT Safety Center that takes on the more modest role of a clearinghouse or a public-private partnership. Importantly, in determining whether an agency has the power to take a particular action, one should not search for a statutory prohibition, and conclude from the absence of such a prohibition that the agency can take an affirmative act. [56] Instead, as the Supreme Court has repeatedly noted "an agency literally has no power to act . . . unless and until

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National Coordinator Karen DeSalvo, August 4, 2014, at pg. 3, *available at* http://www.healthit.gov/facas/sites/faca/files/STF__Safety_Center_Transmittal_2014-08-05.pdf, envision the Health IT Safety Center as having a "strong" and "gradually grow[ing]" "governance mechanism," language that could imply that the Safety Center will be taking robust regulatory action with respect to HIT. *See* WEBSTER'S THIRD NEW INT'L DICTIONARY 982 (1976) (defining governance as "the act or process of governing"); *see also* BALLENTINE'S LAW DICTIONARY (3d ed. 2010) (defining "govern" as "to direct and control; to regulate; to influence; to restrain; to manage").

[51] For example, the April 2014 Report and the May 2014 Presentation describe the Safety Center as a "trusted convener of health IT stakeholders," *see* FDASIA Report at 14; *see also* May 2014 Presentation at 15, a moniker that implies that the Health IT Safety Center's role is limited to merely assembling various HIT stakeholders in a central location. *See* WEBSTER'S THIRD NEW INT'L DICTIONARY 497 (1976) (defining "convener" as "one that convenes, esp. the chairman of a committee or other organized body of persons."); *see also* BALLENTINE'S LAW DICTIONARY (3d ed. 2010) (defining "convene" as "to assemble; to meet as a body; to call a meeting"). And in a July 2014 letter to the House Committee on Energy and Commerce, the National Coordinator of ONC explicitly states that the April 2014 Report "did not propose that the Health IT Safety Center would have the authority to regulate health IT." *See* Karen B. DeSalvo, Letter to The Honorable Fred Upton, Chariman, Committee on Energy and Commerce, July 8, 2014, at pg. 2, *available at* http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/20140708ONCresponse.pdf (hereinafter "July 2014 Letter"). The July 2014 letter is echoed by the August 2014 suggestions from the Policy Committee that envision the Safety Center as operating in a "non-regulatory role," *see* Paul Tang, *Letter to National Coordinator Karen DeSalvo,* August 4, 2014, at pg. 2, *available at* http://www.healthit.gov/facas/sites/faca/files/STF__Safety_Center_Transmittal_2014-08-05.pdf., and by the RTI Road Map which explicitly states that the Health IT Safety Center will not "exercise . . . regulatory authority." *See* RTI Road Map at 3.

[52] *Id.* at 5 (noting that the exact details for a proposed Health IT Safety Center is still a work-in-progress).

[53] *See* 42 U.S.C. § 300jj-16(a)(1) ("[N]othing in such Act or in the amendments made by such Act shall be construed . . . to require a private entity to adopt or comply with a standard or implementation specification adopted under section 3004").

[54] *Id.* § 300jj-16(a)(2). It should be noted that the HITECH Act authorizes the National Coordinator to "establish a governance mechanism for the nationwide health information network," *see id.*§ 300jj-11(c)(8), but nowhere does the statute define what a "governance mechanism" entails.

[55] *See supra* "ONC and its Current Legal Authority."

[56] *See* Fag Italia S.P.A. v. United States, 291 F.3d 806, 816 (Fed. Cir. 2002).

Congress confers power upon it."[57] Accordingly, agencies are a "creature of statute, and may act only because, and only to the extent that, Congress affirmatively has delegated them the power to act."[58]

Applying this principle to the instant matter, even if ONC does not foresee the Health IT Safety Center as taking on a regulatory role—an act that is specifically prohibited by the HITECH Act–and instead merely envisions the Safety Center as being either a clearinghouse or a private-public partnership that collects and disseminates information on HIT matters, ONC cannot legally engage in such activity without an affirmative grant of authority from Congress.[59] The operative question, therefore is whether ONC can point to any affirmative grants of authority that either implicitly or explicitly authorize the establishment of a wholly new public-private entity that acts as a national clearinghouse on HIT issues, including perhaps providing educational programs or issuing analytical reports on HIT matters.

In the July 2014 letter to the House Committee on Energy and Commerce, the National Coordinator pointed to three statutory provisions to demonstrate that Congress had affirmatively granted the agency the authority to establish the Health IT Safety Center. First, the National Coordinator argued that Congress authorized the establishment of the Safety Center though section 3001(b) of the PHSA,[60] which broadly discusses the "purposes" of the National Coordinator.[61] Specifically, the letter cited section 3001(b)(11),[62] which states that the "National Coordinator shall perform the duties under subsection (c) in a manner consistent with the development of a nationwide [HIT] infrastructure that allows for the electronic use and exchange of information and that – promotes a more effective marketplace, greater competition, greater systems analysis . . . ."[63]

Section 3001(b)(11), however, may be a thin reed on which to base the establishment of the Safety Center. While Congress need not expressly delegate every action in order for an agency to lawfully take a specific action,[64] agency action must necessary follow from, and be consistent with, the operative governing legislation, [65] and an agency cannot take action merely because a statute is broadly or ambiguously worded.[66] More specifically, courts have rejected reading a statute's broad purposes as a source of authority for an agency, particularly where Congress has explicitly delineated the boundaries of an agency's authority elsewhere in a statute.[67] With respect to the PHSA, Congress announced the broad

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[57] *See La. Pub. Serv. Comm'n,* 476 U.S. at 374; *see also* Lyng v. Payne, 476 U.S. 926, 937 (1986) ("[A]n agency's power is no greater than that delegated to it by Congress."); American Fin. Servs. Ass'n v. FTC, 767 F.2d 957, 965 (D.C. Cir. 1985) ("The extent of [an agency's] powers can be decided only by considering the powers Congress specifically granted it in the light of the statutory language and background.").

[58] American Bus Ass'n v. Slater, 231 F.3d 1, 9 (D.C. Cir. 2000) (Santelle, J., concurring).

[59] *See American Fin. Servs. Ass'n,* 767 F.2d at 965 (holding that an agency's power can only be decided by considering the "powers Congress *specifically* granted it in the light of the statutory language and background.") (emphasis added).

[60] *See* July Letter at 2.

[61] 42 U.S.C. § 300jj-11(b)(10).

[62] *See* July Letter at 2.

[63] 42 U.S.C. § 300jj-11(b)(10).

[64] *See* Whitman v. Am. Trucking Ass'ns, 531 U.S. 457, 472 (2002) (holding that Congress need only lay down an "intelligible principle" to an agency); *see also* Morton v. Ruiz, 415 U.S. 199, 231 ("The power of an administrative agency to administer a congressionally created . . . program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress.").

[65] *See Ruiz,* 415 U.S. at 232.

[66] *See* Michigan v. EPA, 268 F.3d 1075, 1082 (D.C. Cir. 2001) ("Mere ambiguity in a statute is not evidence of congressional delegation of authority.").

[67] *See* Mertens v. Hewitt Assocs., 508 U.S. 248, 261 (1993); *see also* Platte River Whooping Crane Critical Habitat Maint. Trust v. FERC, 295 U.S. App. D.C. 218, 962 F.2d 27, 33 (D.C. Cir. 1992); *see generally* MCI Telecomms. Corp. v. AT&T Co., 512

(continued...)

purposes of the role of the National Coordinator in section 3001(b), but explicitly tied those broad purposes to the duties the National Coordinator possesses under section 3001(c).[68] Put another way, section 3001(b) broadly outlines the general goals envisioned for the National Coordinator, but the plain language of the HITECH Act indicates that section 3001(b) was not meant to be a source of authority for National Coordinator's actions.

Perhaps acknowledging the limits of attempting to establish the Health IT Safety Center based on the language in section 3001(b)(11) of the PHSA, the July 2014 letter cites to PHSA section 3001(c)(5) as an additional source of authority for ONC to establish the Safety Center.[69] As discussed above, section 3001(c)(5) authorizes ONC to "keep or recognize" a program respecting the "voluntary certification" of HIT, allowing HIT articles to be certified as being compliant with certain certification criteria, which in turn are based on standards and implementation specifications recommended by the HIT Standards Committee and promulgated by the Secretary of HHS.[70] While section 3001(c)(5), unlike section 3001(b), *is* an affirmative grant of authority to ONC, the plain terms of section 3001(c)(5) appear to be limited to authorizing ONC to establish a HIT certification program and do not appear to discuss the concept of ONC establishing and running a national clearinghouse or public-private partnership on HIT matters.[71] Section 3001(c)(5) does not appear, for example, to explicitly or even implicitly authorize ONC to run an education program or issue reports from a Safety Center, but instead the section is focused on the issue of HIT certification. Moreover, the HITECH Act already establishes advisory committees composed of stakeholders, such as the HIT Policy Committee[72] and the National Committee on Vital and Health Statistics,[73] and a rulemaking process that itself requires stakeholder comment and input.[74] It is unclear why ONC has authority based on section 3001(c)(5) to establish an *additional* means of facilitating input from private industries on HIT issues. As one court has noted, "when Congress has made an explicit delegation of authority to an agency, Congress did not intend to delegate additional authority *sub silentio*,"[75] meaning that section 3001(c)(5) cannot be read so expansively as to provide ONC with powers that the section simply does not contemplate.

Finally, the July 2014 letter suggests that PHSA section 3011 provides a basis for the ONC's authority to establish the Health IT Safety Center.[76] Section 3011, which authorizes funding to strengthen HIT infrastructure, is one of several new HIT grant, loan, and demonstration programs established under subtitle B of the HITECH Act.[77] Specifically, section 3011 authorizes the Secretary, "using amounts

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U.S. 218, 231 n.4 (1994) (holding that agencies are bound "not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes.").

[68] 42 U.S.C. § 300jj-11(b) ("The National Coordinator shall perform the duties *under subsection (c)* in a manner consistent . . . .") (emphasis added).

[69] *See* July 2014 Letter at 2.

[70] *See supra* "ONC and its Current Legal Authority" at 2-3.

[71] While the HITECH Act contemplates public and private collaboration on HIT issues, the context of such collaboration and the authority provided to ONC with respect to coordinating such collaboration appears to be limited on the face of the statute. *See, e.g.*, 42 U.S.C. § 300jj-11(c)(3)(B) (authorizing ONC to publish a HIT strategic plan that is "updated through collaboration of public and private entities"); *see also* 42 U.S.C. § 300jj-31(b) (authorizing the Secretary to "create a [HIT] Research Center" whose purpose is – in part—to "accelerate the transfer of lessons learned from existing public and private sector initiatives").

[72] *See* 42 U.S.C. § 300jj-12.

[73] *See* 42 U.S.C. § 242k; *see also id.* § 300jj-12 (c)(8); *id.* § 300jj-13(b)(5).

[74] *See* 42 U.S.C. § 300jj-14(a)(2)(A).

[75] Texas v. United States, 497 F.3d 491, 503 (5th Cir. 2007).

[76] *See* July Letter at 3 ("In addition, PHSA section 3011 . . . .").

[77] *See* 42 U.S.C. §§ 300jj-31 – 300jj-37.

appropriated under section 3018," to invest in HIT infrastructure "necessary to allow for and promote the electronic exchange and use of health information for each individual in the United States . . . ."[78] Section 3011 funds must be invested by the Secretary of HHS through "different agencies with expertise," including ONC for several purposes, including the "promotion of technologies and best practices that enhance the protection of health information . . . ."[79] While the establishment of a HIT clearinghouse by ONC may arguably be an investment in HIT "infrastructure" that promotes "best practices that enhance the protection of health information,"[80] it is unclear whether the HITECH Act as currently written authorizes the establishment of a Health IT Safety Center based on section 3011. The plain language of section 3011 limits the use of funds to those "appropriated under section 3018,"[81] which in turn states that "[f]or the purposes of carrying out [subtitle B of the HITECH Act]" – which necessarily includes section 3011 – appropriated sums are authorized "for each of the fiscal years 2009 through 2013."[82] In other words, it is difficult to see how section 3011 authorizes ONC to establish a Health IT Safety Center in the year 2014 or thereafter, when the plain terms of section 3011 are temporarily limited to fiscal years 2009 through 2013.[83]

In short, the July 2014 letter from ONC does not appear to provide a clear basis for why the agency has the authority to establish a Health IT Safety Center, even if that entity acts in a non-regulatory capacity. While perhaps other parts of the HITECH Act or other laws authorize ONC to establish the Safety Center, many of ONC's statutory authorities are either (1) tied to incentive programs that are limited in scope or have expired or (2) are purely ministerial in nature.[84] More to the point, the agency has not suggested any other sources of law authorizing the creation of the Health IT Safety Center, and if the agency were to solely rely on the three legal sources identified in the July 2014 letter, legal questions could arise with respect to ONC's authority to establish the Safety Center.[85] Nonetheless, as discussed earlier, because the exact nature of Health IT Safety Center is unknown and because ONC's legal justifications for the Safety Center may change or may become more refined, a definitive conclusion as to the legality of the proposed Health IT Safety Center is not possible in this memorandum.

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[78] *See* 42 U.S.C. § 300jj-31(a).

[79] *Id.* § 300jj-31(a)(6).

[80] *Cf.* BLACK'S LAW DICTIONARY (9th ed. 2009) (defining infrastructure as "[t]he underlying framework of a system; esp., public services and facilities (such as highways, schools, bridges, sewers and water systems) needed to support commerce as well as economic and residential development").

[81] *See* 42 U.S.C. § 300jj-31(a).

[82] *Id.* § 300jj-38.

[83] An agency cannot act other than by appropriation from Congress, *see* Environmental Defense Ctr. v. Babbitt, 73 F.3d 867, 871-72 (9th Cir. 1995), and if the agency expends any resources – such as salaries, employees, paper, or buildings – to accomplish a particular task, such expenditures need to be a product of an appropriation by Congress. *Id.; see also* United States Dep't of the Navy v. Fed. Labor Rels. Auth., 665 F.3d 1339, 1347 (D.C. Cir. 2012) (holding that Congress' "control over federal expenditures is 'absolute'" and an agency is not authorized to make "expenditure[s] of funds beyond what Congress has approved."); *see also* Highland Falls-Fort Montgomery Cent. Sch. Dist. v. United States, 48 F.3d 1166, 1171, 1172 (Fed. Cir. 1995) (same) (citing 31 U.S.C. § 1341(a)(1)(A) & 31 U.S.C. § 1532))

[84] *See supra* "ONC and its Current Legal Authority" at 3-4.

[85] As such, this memorandum is not meant to suggest that the establishment of the Safety Center would be unlawful, as such a conclusion would necessitate proving the "negative" that no laws exist in the corpus of American law that authorize ONC's conduct. Instead, the memorandum merely concludes that the July 2014 letter from ONC has not provided a clear source of authority for establishing the Health IT Safety Center.

AMERICAN ACADEMY of ACTUARIES
Objective. Independent. Effective.™

February 24, 2015

The Honorable Sylvia Mathews Burwell
Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Premium rate filing implications of *King v. Burwell*

Dear Madam Secretary:

On behalf of the American Academy of Actuaries'[1] Health Practice Council, I would like to urge you to consider implementing measures to counter the potential adverse consequences on health insurance premium rate filings in the event the Supreme Court rules for the petitioners in *King v. Burwell.* If no action is taken to allow enrollees access to premium subsidies in states participating in the federally facilitated marketplace (FFM),[2] there will be fewer individual market enrollees and higher average health care costs in those states. As a result, premiums for 2015, which are already in place, and premiums for 2016, which need to be submitted prior to the court's ruling, would likely be inadequate to cover claims. The U.S. Department of Health and Human Services (HHS) and state authorities should consider allowing contingent premium rate submissions and/or revised submissions to help mitigate the potential for inadequate 2016 premiums in FFM states.

Eliminating subsidies in FFM states would likely result in significantly fewer individual market enrollees and higher average health care costs

Along with the individual mandate, and other provisions of the Affordable Care Act (ACA), the premium tax credits are designed to increase participation in the health insurance market and help ensure that the insurance risk pools include not only higher-risk individuals, but also lower-risk ones. Without these provisions, the law's guaranteed issue and modified community rating requirements would put upward pressure on premiums.

If federal premium tax credits are no longer available to eligible enrollees in FFM states, enrollment could decline precipitously. Moreover, individuals with high-cost health care needs would be more likely to remain enrolled, while those with low-cost health care needs would be more likely to exit the market. Such adverse selection would cause average health care costs, and therefore premiums, to rise. Estimates from the Urban Institute suggest that nearly 10 million

[1] The American Academy of Actuaries is an 18,000+ member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.
[2] The federal government could act to make premium subsidies available in FFM states. FFM states could make premium subsidies available by establishing a state-based exchange.

fewer people would have coverage in the individual market and the change in the health mix of enrollees would increase premiums by 35 percent in the affected states.[3] Another analysis from the RAND Corporation estimates that eliminating the premium subsidies in *all states* would result in a premium increase of nearly 45 percent.[4]

Issuers are limited in their ability to change premiums for 2015 and 2016
Although eliminating premium tax credits in FFM states would result in higher average health care costs in the individual market, the ability for issuers to increase premiums to meet those higher costs would be limited for the 2015 and 2016 plan years. For 2015, premiums are already in place and ACA regulations prohibit mid-year premium changes. If individual market plans experience significant disenrollment during the latter months of 2015, premiums likely would be insufficient to cover claims. This raises solvency concerns, especially among issuers for whom exchange business is a relatively large share of their book of business.

Based on the Centers for Medicare & Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) 2016 letter to issuers in the FFM, issuers are required to file their 2016 plan year premiums by May 15, and the deadline for states to approve rates is August 25.[5] The May 15 submission deadline likely will occur before the Court issues its ruling. Although some states have flexibility in holding rate filings open until the August 25 deadline, many states have strict timeframes regarding how much time can elapse between a rate-filing submission and when that filing must be approved or denied (e.g., 30 days). If issuers are not allowed to submit revised rates after the CMS deadline, premiums likely would be insufficient to cover claims if the Court rules in favor of the petitioners.

Allowing contingent premium rate submissions and/or revised submissions would help mitigate the potential for inadequate 2016 premiums
If no action is taken to allow enrollees access to premium subsidies in the affected states, there are options to help mitigate the potential for inadequate 2016 premiums. One option is for HHS and states to allow issuers to submit two sets of contingent premium rates—one set reflecting pricing assumptions that would be appropriate if premium tax credits continue to be available and the other reflecting pricing assumptions that would be appropriate if premium tax credits are no longer allowed. Although issuers can submit only one unified rate review template (URRT) to the federal Health Insurance Oversight System (HIOS), this option would allow issuers to submit both sets of rates and corresponding justifications in the rate filings submitted to states. Submitting both sets of rates and corresponding justifications would make it feasible for revised rates to be approved within the timeframes needed to implement the rates by the start of the open enrollment period.

Another option is to allow issuers in affected states more flexibility to revise and resubmit their rates should the Court rule that premium tax credits are not available. States that can hold filings open until the approval deadline could consider doing so to allow issuers to amend the rates. In states that have stricter timeframes, HHS could consider allowing revised filings to be submitted after the May 15 submission deadline. Using an open enrollment period and approval deadlines

[3] Linda J. Blumberg, Matthew Buettgens, and John Holahan, "The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums." Robert Wood Johnson Foundation and the Urban Institute. January 2015.
[4] Christine Eibner and Evan Saltzman, "Assessing Alternative Modifications to the Affordable Care Act: Impact on Individual Market Premiums and Insurance Coverage." RAND Corporation. 2014.
[5] Available from: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf.

that are similar to those used in the 2015 plan year would help provide adequate time to review any revised rate-filing submissions.

* * * * *

The American Academy of Actuaries' Health Practice Council encourages you to consider implementing these options in affected states to help ensure that premiums for 2016 are adequate. Otherwise, insurer solvency could be threatened. We would welcome the opportunity to discuss our concerns and comments with you in more detail. If you have questions or would like to meet with us, please contact Heather Jerbi, the Academy's assistant director of public policy, at 202.785.7869 or Jerbi@actuary.org.

Sincerely,

Catherine Murphy-Barron, MAAA, FSA
Vice President, Health Practice Council
American Academy of Actuaries

Cc: Sen. Ben Nelson, Chief Executive Officer, NAIC
Monica J. Lindeen, President, NAIC
Members of the U.S. House of Representatives
Members of the U.S. Senate

February 9, 2015

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Paul Ryan
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen and Ranking Members:

We are writing on behalf of nearly 60 patient groups to urge you to oppose any legislative proposals that would increase co-pays for brand medicines used by Low-Income Subsidy (LIS) beneficiaries in the Medicare Part D program. In his Fiscal Year 2015 and 2016 budgets, the President included provisions that would double the statutory brand drug copayments for LIS beneficiaries. While these proposals are meant to encourage the use of generic drugs, if enacted, this change would have harmful effects on a particularly vulnerable patient population. Specifically, these proposals could reduce medication adherence, compromise patient outcomes, and raise overall Medicare costs.

LIS beneficiaries often have multiple chronic conditions, higher rates of disabilities, and more functional or cognitive impairments than non-LIS enrollees. As a result, any changes in medication can be particularly harmful for these beneficiaries. About half of all LIS beneficiaries qualify for Medicare before age 65 due to a disability, compared to 15 percent of non-LIS beneficiaries. Overall, LIS beneficiaries tend to be in worse health than other Medicare beneficiaries, and therefore may need multiple brand medicines to treat their chronic and often complex conditions. This means that higher copays would disproportionately penalize this population.

Since LIS enrollees by definition have incomes below 135% of the federal poverty level, they have very limited resources to pay out-of-pocket costs. Further, in many states, full benefit dual eligibles fall below 100% of the federal poverty line. Even nominally increasing cost-sharing could force them to forego, delay, or decrease use of their prescribed medications. A decline in medication adherence will only lead to poorer health outcomes, which in turn will cost the Medicare and Medicaid programs even more in avoidable hospitalizations and other unnecessary medical care. We should be encouraging

these patients to take the medications their doctors prescribe rather than giving them reasons to skip doses or switch medicines, which could disrupt their treatment plans.

Lastly, proposing changes to copayments in order to encourage the use of generic drugs is not necessary, since data from the Medicare Payment Advisory Commission (MedPAC) shows LIS beneficiaries already have high generic utilization rates. In 2011, 74% percent of prescriptions for these Part D enrollees were filled with generic drugs and that percentage is steadily increasing.

We strongly urge you to protect LIS beneficiaries – a particularly vulnerable population with high rates of disability, significant health care needs, and limited resources – by preserving their access to the medicines they need.

Sincerely,

American Association of Cardiovascular and Pulmonary Rehabilitation
American Congress of Community Supports and Employment Services
ADAP Advocacy Association (aaa+)
AIDS United
Allergy & Asthma Network
Alliance for Patient Access
Alpha-1 Foundation
American Association for Respiratory Care
American Association on Health and Disability
American Autoimmune Related Diseases Association (AARDA)
American Lung Association
American Thoracic Society
Blue Ribbon Advocacy Alliance
CHOW Project
Community Access National Network
COPD Foundation
Easter Seals
Epilepsy Foundation
For Grace
The Hepatitis C Mentor and Support Group, Inc.
HealthHIV
Hep Free Hawaii
Hepatitis Education Project
HepTREC @ University of the Sciences
Knights of Columbus
Lupus and Allied Diseases Association, Inc.
Lupus Foundation New England
Lupus Foundation of America
Lupus Foundation of Florida Inc
Lupus Foundation of PA
Lupus Foundation of Southern California
Lupus LA
Lupus Research Institute
Lupus Society of Illinois
Michigan Lupus Foundation

Nat Minority AIDS Council
Nat'l Association for Medical Direction of Respiratory Care
National Alliance of State & Territorial AIDS Directors
National Alliance on Mental Illness
National Association of Nutrition and Aging Services Programs
National Black Nurses Association
National Council for Behavioral Health
National Minority Quality Forum
National MS Society
National Organization for Rare Disorders
National Viral Hepatitis Roundtable
Ovarian Cancer National Alliance
Parkinson's Action Network
Power of Pain Foundation
Project Inform
S.L.E. Lupus Foundation
Society for Women's Health Research
The AIDS Institute
The Arc of the United States
The Mended Hearts, Inc.
U.S. Pain Foundation

cc: Majority Leader Mitch McConnell
Minority Leader Harry Reid
Majority Whip John Cornyn
Minority Whip Richard Durbin
Speaker John Boehner
Majority Leader Kevin McCarthy
Minority Leader Nancy Pelosi
Majority Whip Steve Scalise
Minority Whip Steny Hoyer

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THE NEW HEALTH CARE

How Medicaid for Children Partly Pays for Itself

JAN. 12, 2015

Margot Sanger-Katz

When advocates talk about the advantages of government health care, they often talk about a moral obligation to ensure equal access. Or they describe the immediate health and economic rewards of giving people a way to pay for their care.

Now a novel study presents another argument for the medical safety net, at least for children: Giving them health coverage may boost their future earnings for decades. And the taxes they pay on those higher incomes may help pay the government back for some of its investment.

The study used newly available tax records measured over decades to examine the effects of providing Medicaid insurance to children. Instead of looking at the program's immediate impact on those children and their families, it followed them once they became adults and began paying federal taxes.

People who had been eligible for Medicaid as children, as a group, earned higher wages and paid higher federal taxes than their peers who were not

eligible for the federal-state health insurance program. And the more years they were eligible for the program, the larger the difference in earnings.

"If we examine kids that were eligible for different amounts of Medicaid over the course of their childhood, we see that the ones that were eligible for more Medicaid ended up paying more taxes through income and payroll taxes later in life," said Amanda Kowalski, an assistant professor of economics at Yale and one of the study's authors.

The results mean that the government's investment in the children's health care may not have cost as much as budget analysts expected. The study, by a team that included economists from the Treasury Department, was able to calculate a return on investment in the form of tax revenue.

The return wasn't high enough to pay the government back for its investment in health insurance by the time the children reached age 28, when the researchers stopped tracking the subjects. By that age, the Treasury had earned back about 14 cents for every dollar that the federal and state governments had spent on insurance. But it did suggest that, if the subjects' wages continued to follow typical trajectories as they aged, the federal government would earn back about what it spent on its half of the program by the time the children reached 60 — about 56 cents on the dollar, calculated using a formula that took into account the time value of money.

The split in spending between the federal and state governments for Medicaid varies by state, but, on average, federal taxpayers pay 57 cents of each dollar. There may also be some return on investment for states that collect income taxes, but the researchers didn't measure that.

Here's what that means in real numbers: The average person in the study with no Medicaid earned a total of $149,000 by age 28. For each year a person was eligible for Medicaid, that income went up by $250, and the taxes the person paid went up accordingly.

"What's exciting about this is how good the outcome variables that they can look at," said Janet Currie, a professor of economics and public affairs at Princeton. A few studies have tracked the health outcomes of children who were eligible for Medicaid over time, including one Ms. Currie wrote, but the

study's measures of economic outcomes are new.

The new paper was made possible by a series of policy changes throughout the 1980s and 1990s that slowly expanded Medicaid to cover more and more American children. The changes essentially happened in two phases: First, the federal government allowed the program to include older children, and then individual states approved expansion to those groups. The slow, state-by-state spread of the policy enabled the researchers to compare children who were eligible for Medicaid with a control group of similar children of the same age and family income level who were not eligible for the program. The study looked at children who were eligible for Medicaid, even though not every eligible child actually signed up.

Expanded eligibility had two other important effects closely related to the earnings statistics: Children who were eligible for coverage were less likely to die before reaching 28, and they were more likely to attend college. Those are outcomes that, Ms. Kowalski points out, the government may value even if the program doesn't return any money to the Treasury.

The study can't entirely explain how access to childhood health insurance helped low-income children earn more later in life. But Ms. Kowalski has a few theories. One is that it may have helped the girls, in particular, by offering them a way to get contraception (which Medicaid covers to varying degrees in all states) and avoid unplanned pregnancies. The earnings effect was much more pronounced for girls than it was for boys.

The difference may also come from the way that public health insurance changed the budgets of the children's families, she said. By taking care of health care bills, Medicaid may have freed the parents to make other investments in their children's development that paid off.

Ms. Currie said that earlier studies of children's health outcomes also suggest that children with serious illnesses often go on to be sick as adults as well — meaning they are more likely to miss work or have limited career options. Medicaid supports and funds a lot of important preventive health care for very young children. She said the lesson could be that "an ounce of prevention is worth a pound of cure."

Now that the earlier expansions have had a chance to spread, nearly every low-income child in the country is eligible for Medicaid, and more than a third of all American children are currently enrolled in either Medicaid or a closely related federal-state program, called the Children's Health Insurance Program.

"If this is right, then we're going to be seeing a lot more impact for the kids that are born now and in the future," said Judy Solomon, a vice president for health policy at the left-leaning Center on Budget and Policy Priorities.

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A version of this article appears in print on January 13, 2015, on page A3 of the New York edition with the headline: How Medicaid for Children Partly Pays for Itself.

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Save the Children's Insurance

Hillary Clinton and Bill Frist on Health Care for America's Kids

By HILLARY RODHAM CLINTON and BILL FRIST FEB. 12, 2015

NO child in America should be denied the chance to see a doctor when he or she needs one — but if Congress doesn't act soon, that's exactly what might happen.

For the past 18 years, the Children's Health Insurance Program has provided much-needed coverage to millions of American children. And yet, despite strong bipartisan support, we are concerned that gridlock in Washington and unrelated disputes over the Affordable Care Act could prevent an extension of the program. As parents, grandparents and former legislators, we believe that partisan politics should never stand between our kids and quality health care.

We may be from different political parties, but both of us have dedicated our careers to supporting the health of children and their families. This shared commitment inspired us to work together in the late 1990s to help create CHIP to address the needs of the two million children whose families make too much money to be covered by Medicaid, but cannot afford private insurance.

The resulting program, a compromise between Republicans and Democrats, disburses money to the states but gives them flexibility to tailor how they provide coverage to meet the needs of their own children and families. Some expanded Medicaid; others created separate programs. As a result, the number of uninsured children in America has dropped by half. Children miss less school because of illness or injury, and we've seen a significant decline in childhood mortality.

Today, state governments continue to rely on the program to meet crucial

health and budget priorities. It's not surprising that every single governor who responded to a 2014 survey — 39 in all — supported saving CHIP.

Of course, the American health care landscape has changed significantly since CHIP started. Under the Affordable Care Act, many families with children are now receiving financial help to enroll in private health coverage through the new health insurance marketplace. But while it is possible that private, family-wide policies offered by employers and marketplaces may one day render CHIP unnecessary, for now substantial gaps still exist — and too many children can still fall through them.

One specific provision of the Affordable Care Act, often called the "family glitch," has been interpreted to prevent many families from receiving subsidized health coverage in the new marketplace if one parent is offered "affordable coverage" through his or her job. In this case, "affordable" is defined as less than roughly 9.5 percent of household income for that parent to sign up alone — even though the actual cost of available family coverage is far higher. For families affected by this glitch, CHIP may be the only affordable option for making sure their children are covered.

We already know what happens when CHIP is no longer an option for families. According to a recent report from the Georgetown University Health Policy Institute, as many as 14,000 children in Arizona lost their health insurance after 2010, when it became the only state to drop CHIP.

We don't want to see the same thing happen across the country. If CHIP is not reauthorized, more families will be hit with higher costs. As many as two million children could lose coverage altogether. Millions more will have fewer health care benefits and much higher out-of-pocket costs, threatening access to needed health services. And because families without adequate insurance often miss out on preventive care and instead receive more expensive treatment in hospital emergency rooms, all of us will be likely to end up paying part of the bill.

While reauthorization is not due until the end of September, Congress needs to act now. With more than four-fifths of state legislatures adjourning by the end of June, lack of action and clarity from Washington by then will

make budgeting and planning virtually impossible.

Reauthorizing CHIP for the next four years would cost about $10 billion — an investment in our children that will pay off for decades to come. This is an opportunity to send a message that Washington is still capable of making common-sense progress for American families.

As 2015 unfolds, we know Congress will continue to debate the future of health care reform. We most likely won't see eye to eye about some of the more contentious questions. But one thing everyone should be able to agree on is that our most vulnerable children shouldn't be caught in the crossfire.

This isn't about politics. It's about our kids and our nation's future. What could be more important than that?

Hillary Rodham Clinton, a Democrat, was secretary of state from 2009 to 2013, a senator from New York from 2001 to 2009 and first lady from 1993 to 2001. Bill Frist, a Republican, a surgeon and a businessman, was a senator from Tennessee from 1995 to 2007.

A version of this op-ed appears in print on February 13, 2015, on page A27 of the New York edition with the headline: Save the Children's Insurance.

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April 1, 2015

The Honorable Sylvia M. Burwell
Secretary
U.S. Department of Health and Human Services
Washington, D.C., 20504

Dear Secretary Burwell:

Thank you for appearing before the Subcommittee on Health on Thursday, February 26, 2015, to testify at the hearing entitled "Examining the FY 2016 HHS Budget."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Wednesday, April 15, 2015. Your responses should be mailed to Adrianna Simonelli, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Adrianna.Simonelli@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

[Secretary Burwell did not respond to submitted questions by the time of printing.]

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